THE JOURNAL
of the Michigan State Medical Society

VOLUME 52 MAY, 1953 NUMBER 5

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VOLUME 52 MAY, 1953 NUMBER 5

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Saint Paul 14, Minnesota

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Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

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HELP MAKE A 3,000 ATTENDANCE RECORD IN GRAND RAPIDS
MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of March 18, 1953

Seventy-one items were presented to the Executive Committee of The Council on March 18. Chief in importance were:

- *Committee Reports.*—The following were given consideration: (a) Geriatrics Committee, meeting of February 17; (b) Mental Hygiene Committee, meeting of February 18; (c) Special Advisory Committee to Public Relations Counsel, meetings of February 18 and 26; (d) Advisory Committee to State Social Welfare Commission; (e) Joint Committee on Study of Medical Examiner Bill, meeting of February 20; (f) Committee to Study Referral Policy at University of Michigan Hospital, meeting of March 4; (g) Ubiquitous Hosts of M.C.I., meeting of March 4; (h) Rheumatic Fever Control Committee, meeting of March 4; (i) Tuberculosis Control Committee, meeting of March 4.
- The Executive Committee of The Council expressed its appreciation to W. J. Maxey, Lansing, Director of the Michigan Social Welfare Commission, for co-operative effort and experienced help and sound advice in developing a release from liability for divulging confidential communications.
- The Secretary reports that the American Academy of Pediatrics, Michigan Branch, had endorsed the Michigan Rheumatic Fever Control Program, at its meeting in Detroit on March 12.
- The Beaumont Memorial Committee of the State of Michigan (Messers. W. F. Doyle, D. Hale Brake and Joseph Thompson) were thanked for check in the amount of $834.19 payable to the MSMS Beaumont Memorial Fund; this check represented the balance in the State Fund after purchase of the Earley property on Mackinac Island from funds contributed by Parke, Davis & Company, Detroit.

  The sum contributed by members of the Michigan State Medical Society for the Beaumont Memorial construction on Mackinac Island totalled $29,000.09 as of March 18.
- J. M. Wellman, M.D., Lansing, on behalf of Frederick A. Coller, M.D., Ann Arbor, President of the Michigan Chapter, American College of Surgeons, requested co-operation in holding a first meeting of the Michigan Chapter, A.C.S. in Grand Rapids on the Tuesday preceding the MSMS Annual Session (Tuesday, September 22). The Executive Committee of The Council welcomed the relation of MSMS with the Michigan Chapter of the American College of Surgeons, as proposed, and offered all co-operation, and assistance.
- Bills payable were presented, and payment was authorized.
- Wm. A. Hyland, M.D., Grand Rapids, Chairman of the Michigan Delegation to the AMA House of Delegates, reported on the Special meeting of the AMA House of Delegates in Washington, March 14, on the subject of Cabinet rank for Secretary of Social Security, Health and Education.
- C. D. Barrett, M.D., Detroit, was appointed to the Maternal Health Committee; Frank L. Doran, M.D., Grand Rapids, to the Advisory Committee to State Social Welfare Commission; E. C. Swanson, M.D., Vassar, to the Michigan State Medical Assistants Advisory Committee; J. B. Hassberger, M.D., Birmingham, Chairman; J. L. Law, M.D., Ann Arbor, and A. L. Richardson, M.D., Detroit, members of the Subcommittee on Accident Prevention (a committee of the MSMS Child Welfare Committee); F. C. Swartz, M.D., Lansing, to the Michigan Nutrition Council; John R. Rodger, M.D., Bellaire, was appointed official representative of MSMS to attend the National Health Council annual meeting in New York, March 17-19.
- President R. J. Hubbell, M.D., Kalamazoo, was authorized to attend the Annual Session of

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HIGHLIGHTS OF THE EXECUTIVE COMMITTEE

(Continued from Page 470)

the Ohio State Medical Association in Cincinnati on April 21-23 as official MSMS representative.

- C. A. Paukstis, M.D., Ludington, Councilor of the 11th District, was authorized to represent MSMS at the annual convention of Student Branch of American Pharmaceutical Association, in Big Rapids, April 23-25.
- J. S. DeTar, M.D., Milan, was appointed MSMS representative to attend the Workshop conducted by the Commission on Financing of Hospital Care, Chicago, April 24-25.
- Thanks was extended by the Executive Committee of The Council to all who helped to make successful the 1953 Michigan Clinical Institute which had a record attendance of 2,283.
- Wilfrid Haughey, M.D., Battle Creek, was appointed Chairman of the 1954 Michigan Clinical Institute, scheduled for Detroit, March 10-12, 1954.
- The Public Relations Counsel reported on current legislation in the State Legislature; on the publicity during the 1953 M.C.I.; and on the prospects for making a film on Personal Health Appraisal, without cost to MSMS.
- The Subcommittee on Final Plans, Beaumont Memorial Working Committee, reported on details of a contract worked out with Mr. Ely Van Sweden who is ready to begin construction April 1, 1953.
- The Committee on Study of Health and Accident Insurance Program reported on its meeting of March 18 with a representative of the Chicago insurance brokers.
- Matters of mutual interest were discussed with State Health Commissioner A. E. Heustis, M.D., including two legislative proposals.
- The monthly report of Rheumatic Fever Coordinator Leon DeVel, M.D., Grand Rapids, was approved.
- Thanks were extended to Dr. and Mrs. E. I. Carr, Lansing, for preprandial hospitality in their home.

TWELVE PER CENT OF DOCTOR'S TIME GOES TO CHARITY PATIENTS

The average United States physician gives seven hours a week—12 per cent of his working hours—to charity patients. The dollar value of the charity work he does in a single year is more than $3,000.

These figures are revealed in the April issue of *Medical Economics,* national business magazine for doctors The magazine is publishing the results of a nationwide survey it made recently among its 134,000 physician-readers.

According to the survey, about seven out of ten doctors today do some charity work. High-income physicians tend to do more of this work than low-income physicians; and big city doctors, more than those in small towns.

The magazine also found that the average medical man, besides giving *time* to charity, gives $623 a year in *cash.*

PHYSICIANS' COLLECTIONS SHOW SLIGHT DECLINE

The average United States physician collected 85 per cent of the bills owed him by patients last year—a decline of three percentage points in his rate of collections since 1948.

So states the March issue of *Medical Economics,* which is publishing the results of a nationwide survey of medical practice, based on a questionnaire sent to each of its 134,000 physician-readers.

The magazine also found that the average doctor nowadays takes in $2,601 a year from Blue Shield and other health plans. This amounts to about 11 per cent of his gross income.

FORMER MEDICAL OFFICERS SURVEYED

In analyzing 467 questionnaires returned by former armed forces medical officers, the Council on National Emergency Medical Service has extracted pertinent data on percentage of time spent in treatment of military personnel and their dependents, staffing conditions and the number of physicians willing to remain in service.

The survey of former army, navy and air force physicians shows:

1. *Percentage of time.*—Between 44 and 54 per cent of total overseas time was spent in treatment of military personnel and between 39 and 53 per cent of total domestic time. Treatment of

(Continued on Page 474)

FORMER MEDICAL OFFICERS SURVEYED

(Continued from Page 472)

dependents took between 19 and 28 per cent of overseas time and between 25 and 44 per cent of domestic time.

2. *Staffing conditions.*—Overstaffing (136 replies) ranged from 15 to 44 per cent. Understaffing (seventy-nine replies) ranged from 15 to 28 per cent. Adequate (227 replies) ranged from 42 to 58 per cent.

3. *Willing to stay in service.*—214 replied yes; 236, no.

The Council will continue to send out questionnaires to physicians as they return to civilian life. —*AMA News Notes.*

HOUSE OF DELEGATES SUPPORTS NEW FEDERAL DEPARTMENT

The American Medical Association is supporting President Eisenhower's plan for a new Department of Health, Education and Welfare as a "step in the right direction," but at the same time is reaffirming its stand in favor of the ultimate formation of an independent Department of Health. This policy decision was reached by unanimous vote of the House of Delegates today at a special meeting in Washington, called for the sole purpose of acting on the proposal, Reorganization Plan No. 1 of 1953. The House acted by approving in full a report presented by the Board of Trustees, which appears on the reverse page of this Special Report. (For details of Plan, See Letter No. 11.)

First speaker was President Eisenhower, who reminded the Delegates that his administration was in philosophic accord with them, then declared: "We thoroughly understand the importance of your functions. . . . We also understand, and are determined to meet the requirements of our population in the services that only you can provide. . . ." He said the medical profession could do its job better "with the co-operation and friendship of the administration," and pledged that his administration wouldn't attempt to direct medical care "or to be the 'Big Poobah.' "

Others who urged the delegates to approve Plan No. 1 included Senator Taft and Rep. Walter Judd; and Drs. Bauer, Henderson, and Murray. Dr. James R. Reuling presided as Speaker of the House. Among arguments made by the speakers were: 1. This is the first plan to recognize medicine at the top level of a proposed Department. 2. Organizationally it is an improvement over FSA in providing for medical programs. 3. It would give the Secretary greater authority in placing new people in policy-making jobs.

SCROLL PRESENTATIONS

Norman F. Miller, M.D., of Ann Arbor, and Frank L. Rector, M.D., of Lansing, were each presented with a scroll by the MSMS during the Michigan Clinical Institute at a luncheon held in the Pan American Room of the Sheraton-Cadillac Hotel, Detroit, March 12, 1953. More than 110 colleagues and friends attended this luncheon.

R. J. Hubbell, M.D., President, MSMS, presided and presented the scroll to Dr. Miller in honor of his unequaled record of a 100 per cent follow-up of the more than 3,150 cases of gynecological cancer seen by him since becoming head of the Department of Obstetrics and Gynecology at the University of Michigan Medical School, July 1, 1931. This record is unique and unequaled in the annals of cancer therapy.

W. A. Hyland, M.D., as Toastmaster, presented the scroll to Dr. Rector in honor of his long service in lay cancer education in Michigan and elsewhere. For more than twenty-two years Dr. Rector has devoted his professional life to cancer education and the improvement of facilities for the diagnosis and treatment of this disease. For five years he was the Cancer Consultant for the Michigan Department of Health and for the past seven years has been Secretary of the Cancer Control Committee, MSMS. He is the author of *The Story of Cancer for High Schools,* recently issued under the auspices of the Cancer Control Committee.

Each scroll presentation was accompanied by a book of congratulatory letters and messages from co-workers and friends throughout the country.

Among those who registered for this luncheon were:

C. E. Badgley, M.D.; R. H. Baker, M.D.; F. W. Bald, M.D.; Otto O. Beck, M.D.; C. J. Berger, M.D.; O. A. Brines, M.D.; Wm. Bromme, M.D.; Max R. Burnell, M.D.; D. C. Burns, M.D.; L. C. Carpenter, M.D.; F. A. Coller, M.D.; R. C. Connelly, M.D.; H. H. Cummings, M.D.; L. E. Daniels, M.D.; H. W. Dargeon, M.D.; M. A. Darling, M.D.; J. S. DeTar, M.D.; R. E. Dustin, M.D.; D. D. Finlayson, M.D.; A. C. Furstenberg, M.D.; E. C. Galsterer, M.D.; C. B. Gardner, M.D.; M. H. Griswold, M.D.; A. B. Gwinn, M.D.; R. L. Haas, M.D.; J. L. Hammond, M.D.; B. M. Harris, M.D.; L. C. Harvie, M.D.; Wilfrid Haughey, M.D.; H. Henderson, M.D.; A. E. Heustis, M.D.; C. P. Hodgkinson, M.D.; E. S. Hoffman, M.D.; R. J. Hubbell, M.D.; A. A. Humphrey, M.D.; W. H. Huron, M.D.; W. A. Hyland, M.D.; S. J. Hyman, M.D.; C. H. Keene, M.D.; H. W. Longyear, M.D.; Bernie Luck, D.D.S.; H. C. Mathews, M.D.; H. F. Mattson, M.D.; A. B. McGraw, M.D.; H. L. Miller, M.D.; R. S. Morrish, M.D.; H. M. Nelson, M.D.; H. A. Ott, M.D.; J. P. Ottaway, M.D.; H. A. Pearse,

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SCROLL PRESENTATIONS

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M.D.; J. W. Peelen, M.D.; P. S. Peven, M.D.; G. C. Penberthy, M.D.; H. M. Pollard, M.D.; H. W. Porter, M.D.; M. Rebe, M.D.; R. E. Rice, M.D.; J. M. Robb, M.D.; Harold Rock, M.D.; W. F. Seeley, M.D.; C. S. Stevenson, M.D.; W. C. Stout, M.D.; P. E. Sutton, M.D.; F. W. Tamblyn, M.D.; O. E. Todd, M.D.; C. E. Toshach, M.D.; S. W. Trythall, M.D.; Henry Turkel, M.D.; R. W. Waggoner, M.D.; Arch Walls, M.D.; C. J. Westover, M.D.; F. B. Wight, M.D.; H. W. Wiley, M.D., H. B. Zemmer, M.D.

Mrs. H. H. Cornelius, Mrs. Marion Heyser, Mr. D. E. Johnson, Mrs. W. G. Mackersie, Mrs. Marie McAra, Mr. W. F. Newhouse, and Mrs. E. C. Witwer.

DOCTOR DRAFT BILL INTRODUCED

A bill extending the Doctor-Draft to July 1, 1955, was introduced in the United States Senate on April 1. The Defense Department which had drawn up the measure, informed Congress that the administration felt that extension "is considered to be the only means" by which the armed forces can get enough doctors to meet the needs for the next two years.

Provisions in the bill include the continuation of the four present priority groups, service credits are given co-belligerents of World War II, the required period of service remains at two years as does the maximum induction age of fifty-one, men who have served less than a year since June 25, 1950, are liable for recall, but those who have served over a year are not liable during the two-year life of this act, and aliens are made subject to service.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

June 1-5 AMA Annual Session — New York

June 2 Annual Clinic Day, Bon Secours Hospital — Detroit

June 19-20 Upper Peninsula Medical Society Annual Meeting — Escanaba

July 30-31 Annual Coller-Penberthy Medical Surgical Conference — Traverse City

Aug. 20 Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties — Grayling

Sept. 22 Michigan Chapter, American College of Surgeons — Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION — Grand Rapids

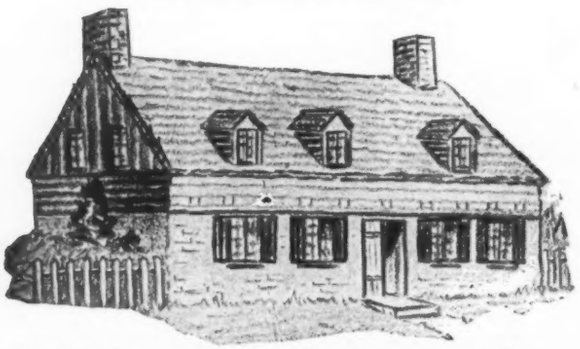
Oct. 21 Michigan Cancer Conference — East Lansing

Autumn MSMS Postgraduate Extramural Courses — Statewide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Proposed

BEAUMONT MEMORIAL



"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

Beaumont Memorial Restoration Committee
Box 539, Lansing 3, Michigan

I attach my check in the amount of: $.....
OR
I pledge the amount of: $.....

payable on or before.....
to assist my fellow doctors of medicine of Michigan in building the Beaumont Memorial on Mackinac Island, Michigan.

..... M.D.

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street

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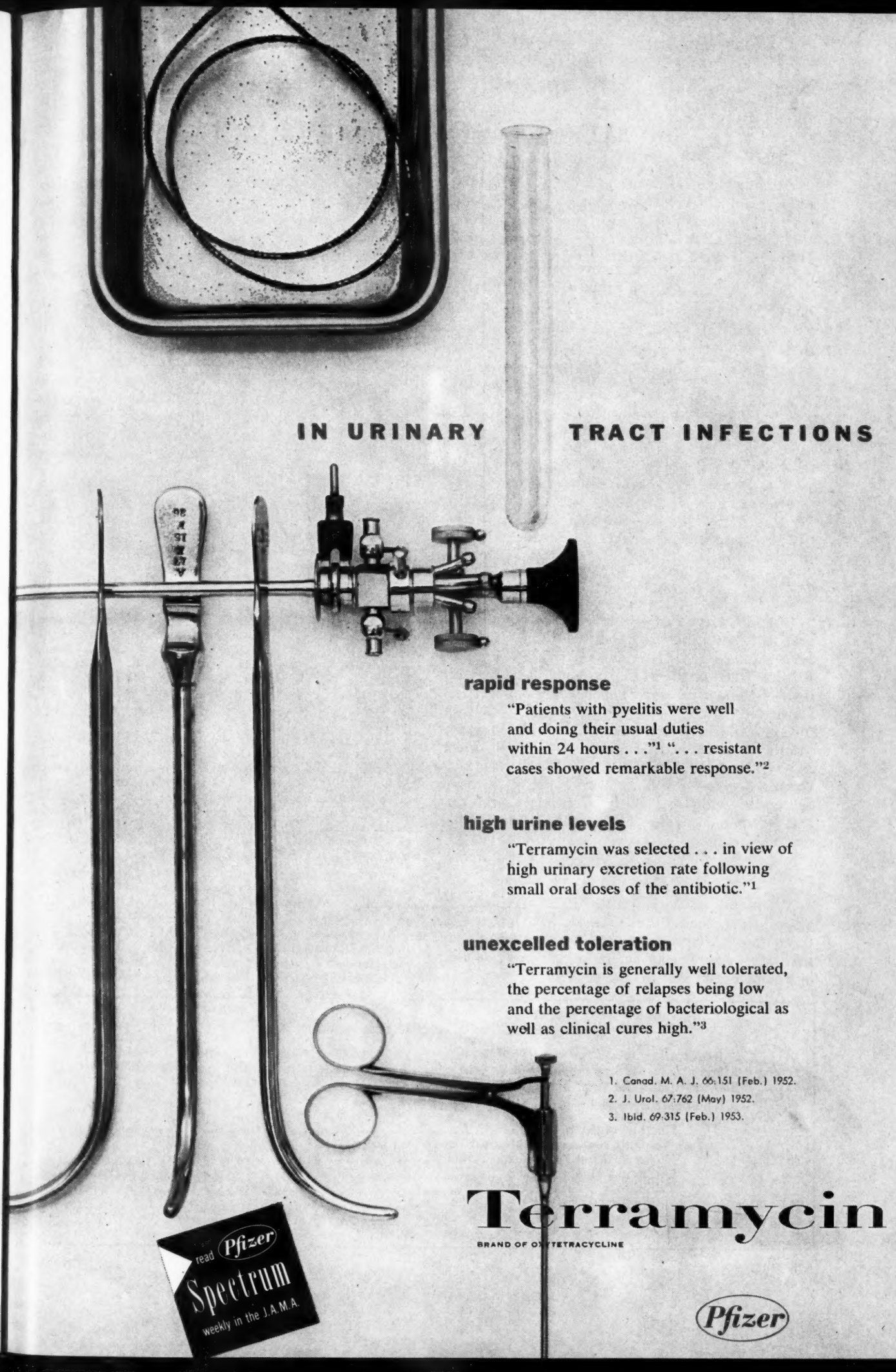
city state


IN URINARY TRACT INFECTIONS
rapid response
"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[1] ". . . resistant cases showed remarkable response."[2]
high urine levels
"Terramycin was selected . . . in view of high urinary excretion rate following small oral doses of the antibiotic."[1]
unexcelled toleration
"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[3]
1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.
Terramycin
BRAND OF OXYTETRACYCLINE
Pfizer
read Pfizer Spectrum weekly in the J.A.M.A.

M.D.'s, Guests Throng 1953 MCI

Attendance records were broken as doctors of medicine, their wives and guests, exhibitors, medical students and operating room nurses thronged the fourth and fifth floors of the Sheraton-Cadillac Hotel in Detroit during the 1953 Michigan Clinical Institute.

The total registration hit 2,283. It was a marked contrast to the first Michigan Clinical Institute held in Detroit in 1947. On that occasion the attendance was 1,293.

New Features

The three-day scientific program featuring the "block system" of subject matter presentation offered topics of lectures and discussion important to the medical profession. A total of 817 M.D.'s viewed the Davis & Geck motion pictures.

As a new feature this year, the Operating Room Nurses conducted a concurrent meeting with a two-day program of speakers. The meeting filled the English Room to overflowing at all sessions.

Scroll Presentations

In addition to the scientific portion of the MCI, time was set aside to honor deserving members. Five scrolls were presented by MSMS President Reader J. Hubbell, M.D., of Kalamazoo. Recipients of the scrolls were Sherman L. Loupee, M.D., Dowagiac, Michigan's Foremost Family Physician for 1952; Earle A. Irvin, M. D., Detroit, President, Michigan Industrial Medical Association; Harry M. Nelson, M.D., Detroit, President, American Cancer Society; Frank L. Rector, M.D., Lansing, Secretary, MSMS Cancer Control Committee; and Norman F. Miller, M.D., Ann Arbor, University of Michigan.

Publicity

Newspaper coverage of the 1953 MCI reached an all-time high. Newspapers in Detroit and throughout Michigan devoted many columns to the many newsworthy events of the meeting both in advance and during the session.

The outstanding science writers from the three Detroit newspapers covered every highlight of the meeting. A few of the papers also featured picture stories which were given prominent position in all editions.

Incidentally, 2,642 bottles of Coca-Cola were dispensed during the meeting.

Thanks to Convention Workers

The Executive Committee of The Council, Michigan State Medical Society, placed on its minutes at the March 18, 1953 meeting in Detroit a vote of thanks to all persons who helped make the Seventh Annual Michigan Clinical Institute a success. Those deserving special mention are:

Committee on Arrangements and Program—J. Milton Robb, M.D., Detroit, Chairman; W. D. Barrett, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo; Otto O. Beck, M.D., Birmingham; L. Fernald Foster, M.D., Bay City; E. F. Sladek, M.D., Traverse City; G. C. Penberthy, M.D., Detroit; C. E. Badgley, M.D., Ann Arbor; H. H. Cummings, M.D., Ann Arbor; A. C. Furstenberg, M.D., Ann Arbor; O. T. Mallery, M.D., Ann Arbor; J. M. Sheldon, M.D., Ann Arbor; Harold Henderson, M.D., Detroit; H. A. Howes, M.D., Detroit; W. S. Reveno, M.D., Detroit; J. H. Schlemer, M.D., Detroit; M. G. Becker, M.D., Edmore; W. C. Beets, M.D., Grand Rapids; R. A. Frary, M.D., Monroe; A. B. Gwinn, M.D., Hastings; W. H. Huron, M.D., Iron Mountain; F. E. Luger, M.D., Saginaw; A. E. Heustis, M.D., Lansing; O. D. Stryker, M.D., Mt. Clemens; and E. I. Carr, M.D., Lansing.

Ubiquitous Hosts—W. B. Cooksey, M.D., Detroit; J. G. Bielawski, M.D., Detroit; W. S. Carpenter, M.D., Detroit; R. C. Connelly, M.D., Detroit; Leon DeVel, M.D., Grand Rapids; O. C. Foster, M.D., Detroit; A. E. Heustis, M.D., Lansing; A. A. Humphrey, M.D., Battle Creek; H. Y. Kasabach, M.D., Detroit; E. E. Martmer, M.D., Detroit; H. M. Nelson, M.D., Detroit; G. C. Penberthy, M.D., Detroit; A. H. Price, M.D., Detroit; and A. B. Stearns, M.D., Detroit.

Chairmen of Assemblies—R. A. Frary, M.D., Monroe; A. B. Gwinn, M.D., Hastings; C. H. Keene, M.D., Willow Run; D. A. Cameron, M.D., Detroit; H. L. Smith, M.D., Detroit; and J. D. Littig, M.D., Kalamazoo.

Press Committee—C. L. Weston, M.D., Owosso, Chairman; A. B. Gwinn, M.D., Hastings; H. F. Dibble, M.D., Detroit; and R. A. Johnson, M.D., Detroit.

Richard A. Aubrey, Detroit, who was loaned by the

Attendance Climbs to New High at 1953 MCI

Registration totals for the 1953 Seventh Annual Michigan Clinical Institute in Detroit, March 11-12-13, reached a new peak and smashed all previous records. The total was 2,283—330 more than the 1952 MCI.

The breakdown included:

Doctors of Medicine	1,342
Woman's Auxiliary & Medical Assistants	80
Guests (Including Medical Students)	229
Operating Room Nurses	280
Exhibitors	352
GRAND TOTAL	2,283

M.D.'S, GUESTS THRONG 1953 MCI

Top Left—Confreres of Earle A. Irvin, M.D., Detroit, President of the Industrial Medical Association, congratulate Dr. Irvin during a testimonial dinner held March 10. Dr. Irvin also received a scroll of appreciation for his distinguished service from the Michigan State Medical Society. Pictured left to right are Henry S. Brown, M.D., Medical Director, Michigan Bell Telephone Company; E. C. Holmblad, M.D., Director, Industrial Medical Association, Chicago; Clarence D. Selby, M.D., former Medical Director of General Motors; Dr. Irvin; Otto P. Geier, M.D., Medical Director (retired) of Cincinnati Milling Machine Company; McIver Woody, M.D., Medical Director (retired) Standard Oil Company of New Jersey; A. H. Whitaker, M.D., Detroit.

Top Right—William Bromme, M.D., Detroit, Chairman of The Council of the Michigan State Medical Society, congratulates Dr. Irvin at the testimonial dinner.

Center—Reader J. Hubbell, M.D., Kalamazoo, President, Michigan State Medical Society, presents a scroll of appreciation to Harry M. Nelson, M.D., Detroit, President of the American Cancer Society, during a testimonial dinner held for Dr. Nelson on March 12 at the Michigan Clinical Institute.

Lower Left—Public Health Officers convene at a meeting during the 1953 MCI. Pictured left to right are J. K. Altland, M.D., Lansing; Thomas M. Rivers, M.D., New York City, Director and Physician-In-Chief of The Hospital of the Rockefeller Institute for Medical Research; Albert E. Heustis, M.D., Commissioner, Michigan Department of Health; and Joseph G. Molner, M.D., Health Commissioner of the City of Detroit.

Lower Right—The Woman's Auxiliary to the Michigan State Medical Society conducted their Mid-Year Board Meeting concurrently with the Michigan Clinical Institute. The officers pictured left to right are Mrs. Ross V. Taylor, Jackson, Recording Secretary; Mrs. Walter Stinson, Bay City, President-Elect; Mrs. William Mackersie, Detroit, President; and Mrs. Elmer L. Whitney, Detroit, Parliamentarian.

E. I. du Pont de Nemours & Co., Inc., gave excellent service during the meeting.

Eugene Wiard and Warren F. Tryloff, Lansing, of the Michigan Health Council; Jack Pickering, science writer, *Detroit Times;* Allen Shoenfield, science writer, *Detroit News;* Louis Cook, science writer, *Detroit Free Press;* Bud Mitchell, Radio Station WJR, Detroit; Charles Gunn, Radio Station CKLW, Detroit; and Bud Lanker, WXYZ-TV, Detroit.

Thanks also are extended to the Michigan Medical Service for the "Doodle Diaries" distributed to registrants.

PR REPORT

How the Story of Foremost Family Physicians Is Told

Michigan's Foremost Family Physician is always one of the top news stories of the Michigan State Medical Society.

Recent selectees for that honor—Sherman L. Loupee, M.D., Dowagiac (1952), and Clayton Willison, M.D., Sault Ste. Marie (1951)—have captured the public fancy partly because they are symbolic of that great institution—the Country Doctor.

Michigan's Foremost Family Physician is good public relations. And since the designated M.D. does much for MSMS PR, the work of presenting him to the doctors of medicine and later the public falls upon the MSMS Public Relations Department.

While Dr. Loupee is being accorded the honors he so justly deserves as the 1952 selection, already preparations have been made for the selection of the 1953 Foremost Family Physician.

Preliminary Plans

Early last January mimeographed forms were sent to the Secretary of all component county medical societies of MSMS. These forms—three pages in length—were for nominations by the county societies of a likely prospect for Michigan's Foremost Family Physician.

Once the county society has selected its most outstanding general practitioner the information on the form is filled in concerning the M.D. selection. The information requested is biographical data plus stories and other remarks which best point out why this particular M.D. should be singled out for the honor.

The county society secretaries return the forms with their nominations by June 1.

After the nominations and the forms are received by the MSMS Public Relations Department, they are studied carefully. In nearly every case the selected M.D. has been too modest in answers to the question on the form. The task then is turned over to the MSMS Public Relations Field Secretaries to obtain more information.

The Field Secretaries talk to a number of the doctor's colleagues, friends and relatives. When the information from the interviews is compiled, it presents a true picture of the practitioner.

All information, photographs, newspaper clippings and magazine stories of the doctor are placed in a separate folder and submitted to The Council in September.

Job of Selection

At the first meeting of The Council of the Michigan State Medical Society, held on the Sunday before the opening of the Annual Session, the Council members consider all the entries. While the task is difficult, they finally decide on three M.D.s as logical choices for that year's Foremost Family Physician award.

The information on the three candidates is turned over to the House of Delegates. One M.D. is selected from the three by popular vote.

Newspaper Publicity

As soon as the selection is announced, the newspaper reporters gathered in the Annual Session Press Room clamor for information. If the new Foremost Family Physician is not present, the reporters have to base their stories on the factual information available until the nominee arrives and can give them the colorful material they request.

If, however, the nominee is present, he is immediately subjected to a brief flurry of activity. He is brought to the Press Room for interviews. After the interviews are completed and the photographs taken, he is escorted on a tour by a member of the MSMS Public Relations staff. During the tour he is photographed by a MSMS photographer shaking hands with the officers and other dignitaries of the Medical Society. The pictures are later used in a story in THE JOURNAL.

American Medical Association Award

In October the MSMS PR staff prepares a brochure on Michigan's Foremost Family Physician for submittal for the American Medical Association Award to the Doctor of the Year. This award is made during the December Clinical Session of the AMA.

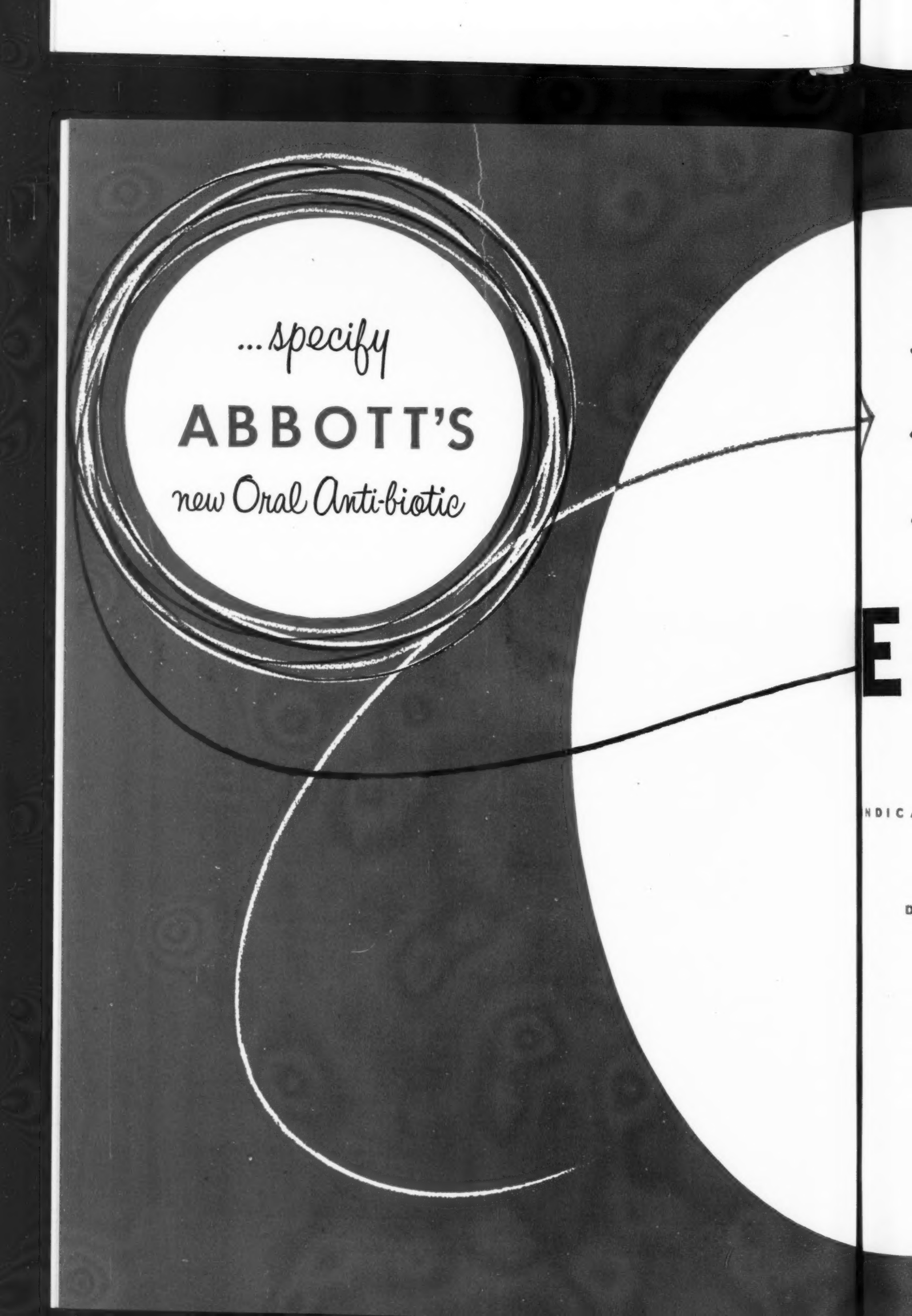
Dr. Willison was named in the top three for this national award in December 1952. A special news release was prepared and distributed to all Michigan daily and weekly newspapers when this was revealed.

MCI and Scroll

Publicity begins again in February for Michigan's Foremost Family Physician and advance news releases are prepared for the Michigan Clinical Institute in March. One advance release is devoted to the story of the Foremost Family Physician and announces that a scroll of appreciation will be presented to the doctor of medicine at the March meeting.

During the MCI, newspapers carry the story of the scroll presentation. But even here the story of Michigan's Foremost does not end. Once again he is honored and recognized for his achievement when the keynote of the May JOURNAL of the Michigan State Medical Society is Michigan's Foremost Family Physician.

Yet while the current Foremost Family Physician is making his final bow, another is prepared off-stage to make an entrance.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ABBOTT'S
new Oral Anti-biotic

Cancer Comment

THE PATIENT WITH INCURABLE CANCER

Our attention in recent years has been focused on the early detection of cancer as it is possible in many types of malignancy to effect a cure while the lesion is still localized. Unfortunately when cancer is first detected by our present methods it is frequently incurable, and the incurable case presents a prolonged difficult problem for medical treatment. While we must, of necessity, place our emphasis on finding new and better ways of detecting and extirpating cancer, we will continue to have for some time to come the discouraged patient, who, in spite of our best efforts, is slowly dying of his incurable neoplasm.

After the patient has reached the inoperable stage there is still much that can be done to make life endurable and worthwhile. Medical treatment, consisting of appropriate analgesics, palliative x-ray therapy, proper diet, graded exercise, carefully considered transfusions, and specific drugs such as nitrogen mustard or hormonal preparations when indicated, is necessary in almost all cases. Surgical treatment such as the resection of an obstructing lesion of the bowel, removal of the gonads, amputation of an ulcerated, foul-smelling surface tumor, or severing of sensory nerve roots, may in selected cases prolong and improve the patient's life. Psychotherapy for the cancer victim and the family is an essential part of the treatment, and is best carried out by the attending physician in his capable everyday manner, optimistic outlook, willingness to listen to the patient's suggestions and complaints, and consideration for the depleted financial condition which prolonged illness usually produces.

The first suspicion of cancer is often aroused in the office of the family physician. Specialists are consulted for confirmation of the clinical findings, and a biopsy is examined by a pathologist to determine the microscopic characteristics of the suspected growth. If the tumor is within the body a surgeon does an exploratory operation to see if complete removal is feasible. Many of the internal neoplasms are incurable when found and it is at this point that the patient becomes a problem for future treatment and unfortunately, often a neglected problem.

The surgeon returns the case to the practitioner, and the family and possibly the patient is informed that the case is considered hopeless. If the physician has the confidence of the patient and continues with regular calls he can keep the patient in a more cheerful frame of mind. The patient may be able to resume his ordinary work and duties for an appreciable length of time and his final period of enforced inactivity is kept to a minimum by the skillful care of the physician.

If the physician does not show a continued interest in the incurable case, the family and patient will seek further advice. They will quickly become a prey to the prevalent quack cancer cures or will turn to the cultist who for a financial consideration is willing to attempt what the medical profession has so inadequately performed. The result is that the finances are exhausted at a time when care is most needed and the treatment which could have made life endurable has been denied. The one thing that the practitioner or specialist must never do is to intimate that the disease is hopeless and nothing more can be done. The attitude of Pilate is no better today than it was two thousand years ago.

With the many board examinations and the great increase in specialization among the present-day graduates, there is a dearth of physicians who treat the patient as a whole rather than as a not too closely integrated group of diseased parts. The present fashion is to treat the illness and all too often the person is forgotten. Being a specialist does not absolve any physician of the responsibility of the care of the patient as an individual. Not only must the specific illness be dealt with, but the patient must be so encouraged that his attitude toward his disease allows him to make a satisfactory adjustment for his terminal illness.

We are all doomed to die, and dying of cancer need not be worse on the average than death from other causes. There is a marked fear of cancer on the part of the layman that makes the problem of care of the incurable case worse than it need be and presents a real challenge to the conscientious practitioner. The outlook of the patient and family, whether hopeful or depressed, indicates the degree of success achieved by the physician in his overall care of the patient. The great numbers of people seeking the cults and quacks for guaranteed cancer cures is a severe indictment of our present practice of medicine.

While any given case of cancer may be hopeless as far as can be determined, it is not wise to tell the family or the patient that death due to the disease is inevitable. We do better as physicians than as prophets, and the case we doom to die of cancer may be struck by an auto first and be killed, or may prove to be an embarassing error in diagnosis, or finally, by means beyond our knowledge, may simply be arrested.

If at all possible, one physician should assume responsibility for the cancer patient, referring him to other therapists for specialized treatment, but always remaining in the background to offer supportive assistance.

* * *

The physician should maintain a consistent attitude with his cancer patient throughout the course of his illness.

Editorial Comment

DR. HAWLEY'S CHARGES

THE charges of "unethical practices" leveled against certain elements of the medical profession by Dr. Paul R. Hawley in an interview with the magazine *U. S. News and World Report,* has touched off the anticipated furor in the medical world.

Reputable physicians in Detroit and elsewhere have reacted quickly, some confirming and some taking issue with the allegations. It is impossible, however, to ignore Dr. Hawley's charges. They come from too reputable a source.

Now director of the American College of Surgeons, he had a long and distinguished career in the Army Medical Corps, formerly headed the Blue Cross-Blue Shield health insurance system, and was chief medical director of the Veterans Administration.

Lest anyone interpret Dr. Hawley's criticism as a plug for socialized medicine, let it be recorded here that he is and has been an outspoken foe of that proposal. He expressed his uncompromising opposition to socialized medicine in a speech before the Detroit Economic Club in March, 1949.

Dr. Hawley suggests that doctors themselves can clean up the unethical practices which he defines as unnecessary surgery, fee splitting, ghost surgery and overcharging, but that to do so, they will have to overcome "an occupational reluctance to testify against each other."

Detroit Free Press, February 19, 1953.

REUTHER ADVOCATES HEALTH PLAN

C.I.O. President Walter P. Reuther went all out last week in support of the program offered by Mr. Truman's Commission on the Health Needs of the Nation.

Speaking at the Philip Murray Awards dinner in New York, he called upon President Eisenhower's administration to redeem Republican campaign promises through promotion by the federal government of "a comprehensive health program for all the American people."

Mr. Reuther suggested that the federal government enlist the aid of states and private practitioners and institutions to provide comprehensive medical care, remedial and preventive, for those who could not afford it.

He also declared that C.I.O. unions would seek improved health and social security provisions in all future contract negotiations.

One of the Philip Murray awards was presented to Oscar Ewing for promoting social welfare legislation.—*AMA Secretary's Letter,* Feb. 16, 1953.

MEDICAL DEBT

Radio and television commercials for loan companies stress the opportunity of the listener to obtain a loan quickly and easily to meet a sudden emergency, which is usually a medical or hospital bill. Although medical bills may be the reason frequently given by applicants for loans from the sponsor, it is not true that medical debts constitute an undue proportion of all consumer debt. Consumers are indebted to a variety of lending agencies. Elsewhere in this issue the Bureau of Medical Economic Research has summarized data recently published in the *Federal Reserve Bulletin* and in the press. The conclusion is that medical debt is currently running about 4 to 5 per cent of total consumer debt. Personal consumer expenditures for medical care are also about 4 per cent of total personal consumer expenditures for all commodities and services. The Bureau contrasts its conclusion with the erroneous interpretations of the same data made by a well-known periodical for the laity. The weakness of the report in this periodical is clearly revealed by the Bureau statement and is an example of the problems facing those who are responsible for medical care.—Editorial, JAMA, Jan. 17. 1953.

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 52 MAY, 1953 NUMBER 5

General Considerations in Geriatrics

By Frank A. Weiser, M.D.
Detroit, Michigan

STATISTICS relative to aging and the aged, such as will be quoted in this essay, have become commonplace in the past few years—commonplace because the facts of an ever-increasing aging and aged population have become a sudden reality. This is already a problem that is challenging the thinking of statemen, social scientists, industrialists and medical men. The most acutely concerned are the aging ones themselves.

Interest in this vexing problem was first brought to the attention of the public at large by the various pension schemes promoted by the oldsters themselves. Most famous of these was the plan suggested by Dr. Townsend. It was looked upon by the disinterested younger segment of our population and by our uninformed leaders as just another "gimme" scheme, a plot to extract something for nothing by the "havenots."

In 1940, there were 9 million people, in the United States, over the age of sixty-five. They represented 6.7 per cent of the total population. In a short ten years, the number had risen to 12 million (or 8.2 per cent) and 1975 will find 19 million people over the age of sixty-five. They will represent 11.3 per cent of the total population. In other words, in less than two generations the number of the oldsters shall have almost doubled. They shall have increased from one in sixteen of the population in 1940, to one in nine. Verily the avalanche is in motion.

Dr. Weiser is Director of Education and Clinical Research, The Grace Hospital, Detroit, Michigan.

Another facet of the problem is illustrated by the shift in the median age of the population. In 1870, half the population was over 20.2 years old—half under 20.2 years. By 1950, the median age had risen to 30.1 years and in 2000 it will rise to 37.4 years.

These changes are due chiefly to advances in medicine that have brought about a decrease in mortality rates. As a result of the decrease in infant mortality, life expectancy increased quite sharply. Over the centuries from the ancient Roman Era to 1900, there was an increase in life expectancy of only seventeen years, from thirty to forty-eight years; while from 1900 to 1950 there was the phenomenal rise from forty-eight to sixty-nine, an increase of twenty-one years.

Still another facet of this aging population is the disparity between males and females as age progresses. In 1950, between the years of sixty-five to sixty-nine, there were eighty-seven males per 100 females; at seventy to seventy-four there were eighty-eight per 100, and at seventy-five and over, eighty-three per 100. So, as the population gets older it also gets more feminine. Females, under average circumstances, outlive their male components by three to five years. In the upper economic levels they may outlive them seven to ten years. Such a rapidly growing segment of the population creates problems in many fields, all more or less related. For instance, as a voting block the aging might well become a new "minority" group with its own needs impelling it to act as a pressure force to obtain pensions, housing and complete medical care.

In these inflationary days it is not uncommon for people who have spent a lifetime providing for old age to find that rising prices have made it necessary to seek supplementary aid to live—just live. In years gone by when most of the popula-

tion lived in rural communities there was ample room to take care of the comparatively few old people in their own homes. Houses were roomier, food was more available at little or no cost because our ancestors were in the business of growing food for others. The cost of keeping aged members of the family was small. As the population shifted from the rural to the urban areas houses became smaller leaving no place for keeping the elders. The machine age diverted hundreds of thousands from the growing of food to the manufacturing of goods and with it they became dependent on others for maintenance. In addition to having no place to keep the aging, it has become costly to feed them. At the present time, most workers are hard pressed to carry out such a program. They have difficulty providing a secure future for themselves.

The testing time for the theories of those who believe that the human has an intrinsic or instinctive feeling of respect for, and desire to protect, the aged is soon at hand. Investigation of cultures by anthropologists tends to show that evidences of parental respect and care by adults stems from the cultural mores of the community and varies from one civilization to another, and that willingness or unwillingness to desert the aged and ill is probably the result of an environmental or tribal custom phenomenon.

Medical research in recent years has contributed greatly to the creation of this complex problem. The reduction of the death rate in infancy was the first step in raising the longevity of the race. Moreover with the discovery of antibiotics and chemotherapy, a large group of adults will be saved for death at a later day. Now with the passing of medicine from the empiric to the specific stage, as a result of research by men trained in the scientific medicine, many of the so-called degenerative diseases are coming under control to prolong further the life of the individual. Only recently a prominent medical scientist expressed the opinion that we are on the threshold of the control of such diseases as poliomyelitis and cancer. And the research attack on the heart disease, the greatest killer of all, is intensive and world wide. With the growth and further maturing of psychiatry there is hope that more of our most crippling mental diseases will become curable.

The medical profession will have a continuing responsibility in the solution of the care of the aging, even greater than it has had in the past, not only in "doctoring" this newcomer to our civilization but in the actual planning of its total care. Our first and traditional obligation will, of course, be in the immediate ministering to aged sick. It is also our function to help the aging to provide medical care for themselves, and that will be accomplished either by making it possible during the individual's productive period of life to buy prepaid hospital and medical care insurance, or by passing the issue to the government for solution. In spite of our fear of governmental interference with medicine, it is necessary to recognize that a good job probably cannot be done without some co-operation with governmental agencies. And this might indeed be the alternate method, and probably is the intelligent approach to the problem. It might be feasible for the government to so insure voluntary health care plans that after the individual has carried them for a stated number of years, a bank specifically set up for that purpose could then carry the premiums with the insuring company. There need be no interference or dictation.

Our profession will want to co-operate with the social scientists in developing a suitable environment for the oldsters to live in, and with industry that supplies the pensions for those retired from employment, and to help industry determine rules and standards for retirement. The specific task of the medical profession in this multi-faceted cooperative, as has been said above, is the care of the sick. As research in geriatrics progresses, knowledge therefrom will be passed on to the public as it is done at present. Already the family doctor has sensed the importance and immensity of this field. In Detroit for the past two winters a group of general practitioners has devoted many hours to the study of geriatrics. These doctors have learned that care of the aging and aged will involve more than just the care of the physical ailments of the patient. They have learned that there are alterations in the physiological workings of the human body which result in alterations in reaction to disease. And they have learned that along with the normal psychologic changes in aging one has to consider the impact of many things that are the accompaniments of living long: as the loss of life mates, loss of friends and loss of employability. They have learned that the family doctor will again be sought as a friend and counsellor, not alone for his skill as a physician.

The Effect of Longevity on Basic Structures

By Karl L. Swift, M.D.

Detroit, Michigan

IN APPROACHING the subject of the anatomy of aging, Dr. Albert Lansing, Associate Professor of Anatomy of the Washington School of Medicine of St. Louis, Missouri, has stated that "What we don't know about the anatomy of aging would be more in order than what we know about the anatomy of aging." The gross symptoms of aging are very obvious, as you well know. The hair becomes sparse or gray, or both. There are superficial skin changes about the face. The bodily contours change. From these and various signs we can estimate with a reasonable degree of accuracy the age of an individual. The point is that the gross external symptoms of aging are readily determined. However, as soon as the viscera are exposed and examined with the naked eye or with the lens, one suddenly finds that it's most difficult to say this is a senile individual, or a middle-aged individual, or a young man, on the basis of the appearance of the viscera. The viscera, on gross examination, are as well preserved in extreme senility as in early youth, whether the individual be 103 or in his early twenties. Therefore we must resort to microscopic studies and micro-incinerated specimens and the ultra-microscope to really determine the changes in tissue caused by aging.

Aging may be defined as a process of unfavorable progressive change, usually correlated with the passage of time, becoming apparent after maturity and terminating invariably in death of the individual, but from the clinical point of view one almost never encounters aging as a cause of death. No one dies from true aging; he dies of complications which accumulate with advancing years—the so-called degenerative diseases, cardiovascular disease, and so on.

Microscopic studies of the liver, cardiac muscle, spleen, prostate, fallopian tubes, nasal epithelium and skin show progressive, degenerative changes as aging goes on. Liver cells show polypoid nuclei. This is a situation which results from the loss of the ability of the nuclei to divide, but division of chromosomes is sustained. Some cells are doing nothing at all and have become pyknotic. Age pigments have been described in nerve cells, in adrenal gland cells, liver cells and in heart muscle. Without exception, every normal heart after the age of thirty shows varied amounts of this pigment. It may or may not be a true age phenomenon, but it clearly correlates with age. Fibrosis appears to be a fairly general age change, well illustrated by the changes throughout the body wherein elastic tissue is gradually replaced by fibrous tissue.

In a study made by Dr. Lansing of the arteries, longitudinal sections of the aorta were made and studied for atheromatous changes. The degree of atheromatosis was most marked in the lower abdominal portion as compared to the thoracic portion. Also the posterior wall of the aorta shows more changes than the anterior wall. Microincinerated specimens of the human aorta of a senile individual show aggregates of calcium which will go up to 17 or 18 per cent of the dry weight of the tissue. The significance of elastic tissue changes in the development of atheromatosis is illustrated by utilizing the pulmonary artery as a basis for study. The pulmonary is embryologically very much like the aorta. Morphologically it is almost indistinguishable from the aorta. It rarely shows any measure of atheromatosis at any age. In the 1 or 2 per cent of cases which do show atheromatosis in the pulmonary artery, it is usually in an individual who shows pulmonary hypertension, mitral stenosis or a congenital defect, hence we can assume that the higher pressure to which the cerebral, coronary, aortic and other vessels are subjected results in a stress which causes a breakdown of elastic tissue followed by calcification, fibrosis and an affinity for cholesterol.

In summarizing, the iliacs and coronaries show degenerative changes first. The aorta is rather slow as is the hepatic artery. The pulmonary shows minimal changes, while the cerebral artery closely parallels the iliac arteries. It is one of the most vulnerable of all the blood vessels. So much for the anatomical discussion of aging.

Physiologically starting with the eye we find a gradual decrease in the elasticity of the lens and this has been accurately measured in aging man. The diminution in elasticity actually starts in childhood and practically all elasticity is lost before sixty years of age.

Impairment of hearing for high pitched sounds seems to be a normal physiological consequence of aging. The average acuity for hearing high tones —high C on the musical scale and upwards—de-

creases progressively. The higher the tone, the more is the average impairment. Below high C, hearing is nearly as good as with younger people. But for bone conduction of the sound there may be a marked impairment for the lower tones and this may be considered as physiologically normal. The severe impairment of hearing for high tones is said to be due to simple atrophy of the nerve end organs in the basal turn of the cochlea.

In the digestive tract, volume of saliva is less and ptyalin content is diminished. Achlorhydria in the stomach increases with advancing age, other secretions diminish throughout the digestive tract. There is an extension of hair baldness, thinning of skin with smoothness and dystrophy of the toe nails. There is degeneration of elastic tissues and much of the subcutaneous fat disappears. We may mention the heat-regulating function of the skin in connection with physiological changes. The old individual cannot tolerate cold as well as he did when he was younger and may suffer from chilliness. It may not be possible to account for this on the basis of inadequate blood flow. Probably the insulation of the skin is not as efficient because of atrophic changes and the removal of subcutaneous fat. Elderly people tend to suffer more seriously from extreme heat.

Itching skin is a process which accompanies aging which undoubtedly is in some way related to decreased endocrine function. Speed, strength and the ability to sustain moderate effort to exhaustion all increase with age to a maximum in early manhood and womanhood, and then tend to decline.

There have been some very interesting studies on the physiological aspect of diet and life span. In the work of McCay, which was done on rats, it was found that a diet quite adequate with respect to quality but given in such inadequate amounts that the growth of the animal was practically at a standstill, increased significantly the life span of the rat receiving the restricted diet. In the same group receiving the same diet *ad libitum*, the life span was greatly shortened by the excessive eating and the obesity. It seems to be the general thought that over-weight persons, the obese person, may have a shorter life span. As it may be inferred from this that people may eat themselves to an early grave, what might be the answer if we seek a remedy? It seems to be a question of energy metabolism studies. It has been well established that a food intake below energy requirements must of necessity reduce body weight.

In this discussion of the pathology of the aged I have summarized the findings of Monroe of Peter Bent Brigham Hospital who tabulated cases over sixty-one years of age from 1913 to 1943—a total of over 7,900 cases, but all of these were not autopsy protocols; some were clinical records. White and Medalia of Massachusetts General and Boston City Hospitals analyzed 1,251 autopsy protocols. Owen of Grace Hospital, Detroit, has analyzed 246 cases over seventy, since 1946.

The resulting summary of nearly 10,000 cases shows that the major causes of death are as follows in the order given.

1. Cardiovascular Disease.
2. Chronic Vascular Nephritis—(Related to Cardiovascular Disease).
3. Pneumonia—chiefly Bronchial.
4. Cancer.
5. Liver and Gall Bladder Diseases.
6. Tuberculosis.
7. Cerebral Hemorrhage and other Brain diseases.
8. Gastric and Duodenal Ulcers.

Owen has stressed the finding of multiple diverticulosis at autopsy, particularly in the descending and sigmoid colon as a possible clue to the slowing up of digestive and bowel function. An analysis of over 400 diverticuli showed over 309 in the colon.

This survey has brought to light some well known and some rather surprising indications of disease incidence in old persons.

This study indicates the need of further analyses of this sort to establish a firmer foundation for the appraisal of measures for the medical care and the prevention of disease in the increasing number of old persons. Social, economic and educational as well as medical advances are to a certain degree dependent on this increasing knowledge.

The management of the geriatric patient encompasses many factors of which drug therapy is only a part. Proper treatment may eliminate infections, but in other diseases our treatment is supportive rather than curative, and many times only palliative. The reactions to drugs, with few exceptions, is similar in all age groups. In elderly patients, our differences in response to drugs are generally those related to changes in absorption and excretion, renal function, liver function or meta-

(Continued on Page 505)

The Proper Examination of an Older Person

By Perry C. Gittins, M.D.
Detroit, Michigan

AN INCREASING number of older persons are receiving treatment for many kinds of illness. There is also an increasing number of aging persons seeking physical examinations. The enlightened public requests this service for the purpose of detecting early signs of disease, and also expects physicians to advise them how they can live longer and happier as they age.

The physician must evaluate all the problems contributing to aging when conducting this examination. We must consider man as a whole unit, his past and present, as well as his future. We must consider the heredity, the family, where he has lived, his social and intellectual accomplishments, marital life, successes and failures, as well as the cumulative effect of diseases which may contribute to lessen his average expectancy.

The family physician has the privilege and satisfaction of examining a family and siblings for two or three generations. His understanding of an older person under such circumstances can be of extreme value.

During the past few months, it was the privilege of a group of family physicians and specialists to study some of the diseases commonly found in elderly patients at the Wayne County General Hospital. Previous to this we had studied the anatomical, physiological, pathological and psychological aspects of aging.* This experience made it possible for us to have a better understanding of what constitutes an examination of an older person.

Anatomical

The anatomical age[1,2] of a person can be roughly determined by outward appearance, the gray hair, changes in the texture of the skin, and by changes in bodily contour. There is a variable difference in the circumferences of the chest and abdomen. We also observe changes in the blood vessels of the eyes. When we look at the extremities, we can see evidence of arteriosclerosis and changes in circulation. These changes occur to a lesser degree in some and more in other people; so we say this man appears to be sixty years old or eighty years old. These are a few of the anatomical changes we observe by simple inspection of the patient. It conveys much more information about the whole person and this concept is fundamental for a good examination.

Physiological

From the physiological standpoint of aging we may observe changes produced by our endocrine glands. The over-activity and the under-activity of the thyroid may contribute to aging. The changes in the function of the gonads at the climacteric of the male and female initiates many of our aging processes. The gradual change in the ability for tissue to repair, the degeneration of elastic tissue and many other physiological changes occur which produce aging without actual disease. We measure some of these physiological changes when we record respiration, pulse and blood pressure, or have an electrocardiogram recorded, following a measured amount of work. The measure of efficiency of the heart, kidneys and pancreas, may give us information of value to the aging person.

Pathological

The pathological age is determined by noting what the cumulative effects a disease or diseases have produced. We may observe a person in his forties affected by a disease, degenerative in nature, which takes years away from this person's natural expectancy.

The early discovery of disease and the removal or the treatment of known disease will break the chain of pathological conditions which will eventuate.

Psychological

Psychological aging occurs in everyone but is variable according to the background of the person, his past interests, successes, his likes and dislikes.

There are various examinations we can conduct to determine psychological changes, but much can be learned as we listen patiently to the way questions are answered. This information is as valuable as the actual finding of a disease, and advice properly interpreted may help the individual pro-

*Directed by Geriatrics Committee of the Wayne County Academy of General Practice.

ceed through life in a satisfactorily adjusted manner.

The History of the Patient

All of the previously mentioned conditions which affect one's aging are constantly kept in mind when we are interviewing an older person.

It is much easier to interrogate the active, alert business man at age forty than it is to question the same person when he is sixty-five or seventy years of age, at which time he may be showing forgetfulness or lengthy explanations of symptoms.

The history can be one of the most important parts of our examination. It requires time, patience and kindness and no display of impatience when we objectively cover the various systems and parts of the body.

We are familiar with some standardized forms, but most physicians individualize their examinations, taking care to record all positive findings of significance in the various systems.

Respiratory.—The cough may be non-productive. Is there pain? What makes it worse?

Cardiovascular.—The patient may complain of increased pain on exertion, shortness of breath, fast pulse, swelling of extremities, increased frequency of passing urine, especially at night.

Gastrointestinal.—Loss of appetite, change of bowel habits, jaundice, pain after eating, emesis of blood, black stools, et cetera, are complaints pointing to disease in this area.

Genitourinary.—Nocturia, frequency, blood in the urine and obstruction to urinary stream may be mentioned. The female may have these complaints as well as vaginal bleeding.

Musculo-skeletal.—Complaints of joint and back pains, muscle weakness are commonly associated with arthritis and decalcification of bone.

Nervous System.—We observe character of speech, memory, hearing, vision. We note sense of balance. He may complain of pain, numbness and headache. We observe for neurotic tendencies and evidences of psychiatric changes.

Family History.—Inquire all about diseases of a familial nature, such as tuberculosis, allergy and diabetes. Also family longevity must be included.

Past Medical History.—Reports of past medical illnesses should not prevent us from searching even though there is a history of a previous examination.

Social History.—The aging person may have habits of work, sleep, eating, drinking or smoking which may be important. The financial status, home life, marital happiness, his fears and desires may have an important relationship to the development of neurosis.

The Physical Examination

If pressed for time, defer the physical examination so that it may be done at a more suitable hour.

The weight, height, temperature, pulse and blood pressure are recorded. We then systematically check the various areas of the body. The skin is examined for pigment, skin tumor and other signs of disease. Examine the neck, axilla and groin for evidence of lymph node enlargements. Look for breast changes. Look for diseases of chest and heart. The abdomen is checked for tumor of viscera, fluid, scars and hernia. A rectal examination is done in both the male and female, and, if indicated, a proctoscopic and sigmoidoscopic examination should be done, especially if there is evidence of blood in the stool.

The female patient should have a pelvic examination and special consideration given to suspicious cervicitis or irregular bleeding.

The extremities should be checked for varicosities, circulatory changes and changes in the reflexes.

Whenever there is any suspicion of early visual changes, an ophthalmoscopic examination must be done. Early changes in hearing may be determined by the use of the audiometer.

The urinalysis and blood count are usually a routine procedure.

Other specialized examinations such as electrocardiogram, x-ray, blood chemistry, et cetera, should be used whenever indicated.

After this is done we should carefully summarize our findings. We may find little or no evidence of disease. If so there may be something in the social life or his habits of work, eating, recreation that may contribute to early aging.

We may find some early signs of hypertension, weight gain, gallbladder disease, sinusitis, prostatitis and many other conditions to which definite treatment may be directed in order to prevent pathological aging processes.

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Treatment of the Elderly Patient

By A. Hazen Price, M.D.
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THE SATISFACTORY treatment of the elderly patient differs from that of the younger person mainly in that it requires much more patience on the part of the physician. He must be willing to listen not only to specific complaints, but also to many apparently irrelevant facts which the patient wants to talk about. If he gives the impression that he is in a hurry, it is apt to be inpreted that he is only superficially interested, and has no time for someone who is old and probably afflicted with some condition for which nothing can be done anyway. Confidence and hope can only be instilled into the patient by a sympathetic understanding of his whole problem, and the development in his mind of a feeling that he has in the physician someone who truly has his interest at heart. When this relationship exists the mere presence of the doctor gives a lift which cannot be duplicated in any other way.

When the older person becomes ill, he is apt to develop a subconscious anxiety about his future. He realizes full well that he has already lived more than half of his life, but he wants to live a few more years to do some of the things he has not had time to do. He wonders whether he will be so incapacitated as to not be able to live as he had previously. Reasonable assurance on the part of the physician to the point of being overly optimistic at times, and even at the expense of being wrong, adds much to the patient's incentive to get well. Emphasis on the good features of his condition gives added encouragement. A worthwhile hope can be given in most illnesses; few are totally hopeless. To youth and middle age the afflictions of the old often appear intolerable enough, to dampen all desire for life, but the truth is "no man loves life like him thats growing old."

It becomes apparent, therefore, that the treatment of the senior members of our society involves much more than the simple prescription of phenobarbital, digitalis or morphine. It entails a careful survey of the over-all problems of these patients. Their worries and anxieties about business, economic insecurity or perhaps about the way their son or daughter has been treating them, all play an important part in disturbing their peace of mind. While emotionally upset they cannot sleep restfully, their digestion is apt to be impaired, their appetite poor, and the attacks of angina are more frequent and severe. Indeed symptoms such as headaches are more often due to environmental stress than to organic changes, and the removal of the stress relieves the symptom. Confusion of variable degree is frequently seen when older people are removed from familiar surroundings, and it is important to recognize this in order that sympathy and reassurance be used instead of sedatives which may only add to the confusion.

The above aspects of the care of any patient represents those phases of the problem which deal with the person who has the illness. Not infrequently this personality evaluation is overlooked in our efforts to adequately treat the specific disease, with the result that the patient fails to show satisfactory progress until his emotional difficulties are understood. This is particularly true of the elderly patient.

While the psychologic management of these patients is of primary importance there are many other general measures which should be kept in mind. Careful attention to many small details in addition to treating the presenting illness adds much to the well-being of the patient. Indeed his comfort should take precedence over all other factors, and everyone concerned, doctors, nurses and relatives, must be made to realize this fact.

If he is in a hospital someone the patient knows should be permitted to stay with him as much as possible. Most older people would rather stay home, and do not adjust themselves well to hospital routine. The bed should be lowered so that he is less apt to fall when getting in and out of bed. A commode alongside of the bed will permit a much easier bowel movement, than trying to use the bed pan. I can think of no condition other than a hip or spinal fracture in which this is not preferable. It is much better that the patient be out of bed several times a day, not only sitting in the chair, but walking about the room. This induces deeper breathing and exercise of the legs which is so important in the prevention of pulmonary and venous stasis. Deep breathing and leg

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exercises in bed should be encouraged if the patient's condition does not permit him being up. Special attention must be given to the back in the prevention of bed sores. Frequent inspection of the sheets should be made for crinkling and dampness, and the back carefully rubbed with alcohol and powdered night and morning. This is a nursing function, but unfortunately some nurses do not function well and need reminding.

A word of caution regarding too extensive and exhausting examinations of these patients is worth while. Meddlesome diagnostic procedures in the elderly should be avoided. The hospital stay should be short and only those studies made which will offer real help in treatment. A patient of seventy-five years of age with arteriosclerotic heart disease and a mass in his chest which is probably an inoperable malignancy will not be helped by a positive diagnosis made through bronchoscopic examination. The only people helped by establishing this with certainty are the doctor and the relatives.

Constipation in the sick person must be recognized and treated before impaction develops. The regularity of habit at stool must be emphasized and can be accomplished most often by proper diet and insistance upon a bowel movement at some specific time each day by the initiating effect of a glycerin suppository or small enema. Cascara and (or) mineral oil at bedtime may also be necessary. A fecal impaction can be extremely uncomfortable and when manual removal is necessary it may prove to be a severe ordeal in the seriously sick.

The treatment of specific systemic disease in the elderly is very little different from the same condition in the younger person, except that certain modifications are necessary depending upon the reactions of the patient, and the degree of hope for relief that can be expected.

A failing heart needs digitalis most often, but the dosage required in the older person is usually less. Not infrequently digitalis causes mental confusion, and this should be thought of when the patient becomes disoriented. Low salt diets are often so unpalatable that the patients will not eat, and in this case the resins are of great help in eliminating salt from the food. The mercurial and theophylline diuretics are likewise a great adjunct in eliminating fluids. The possibility of a hidden thyrotoxicosis in every case of chronic heart disease should be kept in mind even though none of the cardinal signs are present. The therapeutic trial of iodine will oftentimes be diagnostic, and if so the use of radio-active iodine may change the outlook completely. In fact, the use of this form of treatment even if hyperthyroidism is not present has proven of great value in some cases of chronic valvular or non-valvular heart disease.

The relief of angina is afforded in the usual way by nitroglycerin, and other vasodilators. Should the frequent coronary spasm result in thrombosis the symptoms are apt to be much less severe than in the younger person, and what appears to be a minor thrombosis may result fatally when least expected. It is doubtful whether anything is gained by hospitalization of the older person with coronary thrombosis. They are usually much happier if cared for at home.

The hearts of many old people are far from normal, yet quite good enough for the work required of them. When preparing old patients for operation, it is quite common to find more abnormalities than is the case in younger people, but they are frequently of less serious prognostic significance than in youth. No one should be denied the benefits of modern surgery on the basis of age alone if it will add to the patient's comfort. I am thinking particularly of prostatic, gynecologic and ophthalmic abnormalities which frequently create serious handicaps in everyday living. Added care must of course be used preoperatively and postoperatively, particularly with respect to nutrition and fluid balance, but each person is a special problem and must be evaluated individually. Digitalization before operation is indicated only if any signs of failure are evident. If given empirically, it may only create nausea and mental confusion in an otherwise good risk patient. Ambulation before and after surgery is a must, thereby encouraging deep breathing and the prevention of pulmonary stasis and atelectasis with its attendant serious results.

Peripheral vascular disease is present to a variable degree in the older age group and must always be given special consideration. Avoidance of extremes of heat and cold should be urged, as well as tight garters, stockings, and shoes. Meticulous care of the skin of the feet with careful drying after bathing and the application of lanolin to avoid drying and cracking will oftentimes prevent unnecessary infections. Should gangrene of the toes develop, conservative measures are best used as long as possible. It is surprising what can be

accomplished with Buerger's exercises or the oscillating bed, and the avoidance of moist compresses and artificial heat. The latter may be helpful if used for only very short periods in the presence of infection. Maceration of tissue will surely result if not carefully watched. If amputation becomes necessary, it should be done high enough to assure as good a circulation as possible. Modern anesthesia for surgery eliminates most of the risk of shock.

Pulmonary diseases are frequent in this age group because of poor pulmonary circulation and the habit of shallow breathing. Chronic asthmatic bronchitis with the resultant disabling emphysema due to loss of elastic tissue in the alveoli and bronchi is perhaps the most common and most difficult to control. Symptomatic relief can be afforded by a variety of drugs—aminophyllin, ephedrine, and the iodides, together with the antibiotics when acute infection supervenes. In the chronic purulent infections, they are also helpful and in conjunction with the sulphonamides. Education of the patient in how to breathe with his abdominal muscles has proven of tremendous help in many of these cases. W. A. Allen of Baltimore has devised an ingenious set of exercises which are of great aid in minimizing the incapacitating dyspnea of these patients.

Tuberculous infection in these patients is more common than often suspected and should be looked for in every case.

In the elderly patient, thyroid insufficiency is a part of the aging process, but if it is extreme, much of the lethargy and intolerance to cold can be greatly improved with even small doses of thyroid extract. Obesity is mentioned at this time in order to emphasize again that thyroid extract should never be used to reduce weight unless there is an associated hypothyroidism. Overweight must be controlled in the satisfactory treatment of heart disease, arthritis, and diabetes, but only by dietary restriction. Moderate activity, while very desirable in a general way, may seriously aggravate many conditions and should not be advised for weight reduction. Some of the weakness and poor muscle tone of these patients can often be helped by estrogenic or androgenic therapy in carefully controlled dosage.

There are still many phases of specific treatment in the elderly patient which have not been mentioned in the above paragraphs. Space does not permit a complete discussion of all of these. The physician must be guided in the treatment of older patients by the individual needs at the time of the illness, and by the general observation that these patients require less medication and more assurance. They do not tolerate drugs as well as the younger person, especially all types of sedation, barbiturates and morphine in particular. Chloral hydrate or whiskey have a more quieting effect, with less likelihood of side effects.

In conclusion, it should be said that the physician must recognize his responsibility in giving these patients adequate care at all times, being careful not only of what he tells the sick individual, but also how he tells it. Sending the patient home with the diagnosis of "hardening of the arteries" and a prescription for phenobarbital is very poor medicine. We owe these patients much better care.

THE EFFECT OF LONGEVITY ON BASIC STRUCTURES

(Continued from Page 500)

bolic rate which may alter the rate of destruction of the compound and thereby influence toxicity. In general, habits good, bad or indifferent are acquired and fixed by repetition over a period of time and habits of thinking, eating, smoking, sleeping, exercise, et cetera, become fixed in the aged. It is important not to insist upon abrupt changes in the habits of such patients and to never impose restrictions which have not been tried and proven absolutely positive. They may be modified slowly but if advice regarding habits is too restrictive, the patient will not follow the therapeutic suggestions and nothing whatever is accomplished.

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Arthritis and Geriatrics

By J. J. Lightbody, M.D.
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AS THE HUMAN body ages, it proceeds to show objective and subjective signs of deterioration in a variety of ways, but many of the physical complaints of elderly patients are associated with derangement of the musculoskeletal system.

We don't hear the old-fashioned term "lumbago" being used much in medical circles at the present time, not because there are not as many backaches as there used to be, but because of the introduction of new terminologies which have gradually crept into the medical nomenclature. The fact is that through the years we have discovered specific causes for many of the old lumbago pains, and they are now referred to as myositis, fibrositis, radiculitis, arthritis, ruptured disks, et cetera.

As the elderly person approaches that period of life in which he finds his physical energy decreasing and that many of his primary interests in life are waning, he actually begins to lose height and appears shorter as he grows older. The main reason for this is faulty posture which causes the knees to sag a little, the shoulders to stoop a little, the chest to flatten a little, the stomach to protrude a little, and the gait to slow down a little. This characteristic deterioration of posture in the elderly person is very often the cause of many of the aches and pains in the back, neck, and feet of these individuals. Frequently the correction of faulty posture will greatly improve the appearance of the person and make him appear to be much younger and, coincidentally, will alleviate much of the physical discomfort associated with postural defects.

Osteoarthritis

The most common type of specific joint difficulty in the older age group is osteoarthritis, this term actually being a misnomer as it is not an infectious disease but only an aging of the involved joints—a deterioration due to advancing age.

The most common area involved is the spine, particularly the cervical and lumbosacral regions. Cervical osteoarthritis may be the cause of severe basal headaches or severe radicular pains in the neck and shoulders.

The discomfort experienced by the patient does not always parallel the amount of osteoarthritis as seen by x-ray. Frequently, the x-ray shows advanced osteoarthritis, but the patient may have very little pain, and occasionally the patient may have severe pain but the x-ray shows only minimal changes. Ruptured cervical disks are occasionally missed in this group, and this diagnosis should be considered in any severe, protracted, radiating neck pains.

Many of the older group with cervical arthritis gradually develop an anterior angulation of the head on the neck because they continue to use too many pillows under the head at night. Being in bed seven to nine hours daily with the head in a flexed position, the patient will experience considerable discomfort, particularly in the morning, trying to get the head back to a normal, comfortable position. These patients should learn to sleep without pillows or perhaps with a very small pillow so that the cervical and thoracic spine are in approximately equal horizontal positions. Hard mattresses or the use of bed boards under a mattress are considered valuable adjuncts in the treatment of osteoarthritis of the spine. Osteoarthritis of the shoulder is another common cause of disability in this group, and at times is associated with a bursitis of the shoulder.

Bursitis of Shoulder

Subacromial bursitis seems to be increasing in incidence and is one of the most difficult conditions to manage from a clinical standpoint because some cases are very resistant to all types of treatments.

Bursitis of the shoulder usually involves the supraspinatus tendon which frequently becomes involved in calcific deposits in the subacromial area. The amount of calcium as seen by x-ray gives no indication of the severity of the pain as many cases with large calcium deposits have no pain or very little, while others with no calcium or perhaps small flecks present have excruciating pain and tenderness and marked limitation of the shoulder joint.

There are a number of accepted methods of treatment of bursitis, depending occasionally on

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which specialty is taking care of the patient, but more commonly on the length of time and severity of the presenting symptoms plus the presence or absence of calcium as seen by x-ray. Deep x-ray therapy during the acute stage is being used more or less routinely in early cases, and the roentgenologists report considerable success with this type of therapy—although a rather large percentage seem to require several series of this type of treatment. Calcium has been known to disappear from the bursa under treatment with deep x-ray.

Older people are prone to immobilize themselves without much provocation as far as pain is concerned, and, if they do not move the arm and shoulder, this will prolong the convalescence from the bursitis. Manipulation with or without anesthesia is occasionally used by orthopedic surgeons, and this, also, has given good results. Local injection of the bursa with procaine or hydrocortone to stop the acute pain or to attempt to wash out the calcium is occasionally indicated. Physical therapy, particularly hot wet packs, with massage of the shoulder girdle muscles and forearm, and with passive motion of the shoulder, should be maintained as part of a complete program in the treatment of bursitis. If the arm and shoulder on the affected side are immobilized with a sling for too long a period of time, the bones will begin to show disuse osteoporosis, and the muscles of the shoulder and arm will begin to weaken and show evidence of atrophy. Early movement of the extremity is essential.

Osteoarthritis of Hips

Osteoarthritis of the hips, particularly the advanced type of cases (coxae malum senilis), is one of the most disturbing conditions observed in elderly patients because it involves weight-bearing joints, and when the process reaches a state so that the person is unable to move without severe pain, then the problems associated with the general care of this person are increased tremendously. There is a great amount of evidence to show that this common condition of deterioration of the hip is associated with a lack of blood supply to the hip joint—so everything that would tend to improve the local vascular supply would be of some benefit. Orthopedic surgery to the hip with the use of a vitallium cap and hip arthroplasty is getting to be a more common corrective procedure and has prevented many older people from becoming permanent invalids.

Osteoarthritis of Lower Spine

Osteoarthritis of the lower spine, associated with a variety of muscular aches and pains, is very common in the elderly person, and about the only treatment indicated is the use of a variety of heat applications with massage. Ruptured lumbar or lumbosacral disks are often overlooked in the presence of low spinal arthritis, and if the clinical picture of a ruptured disk is clear-cut and the myelographic x-ray definitely localizes the lesion, then surgery is indicated—otherwise conservative treatment with physical therapy, rest, and sedation is preferable.

Osteoarthritis of the knees is a common condition found in the elderly patient and is often associated with sterile effusions into the joint or bursae. Conservative treatment with moderate rest and frequent physical therapy usually takes care of these patients, although corrective orthopedic surgery procedures such as synovectomy are occasionally indicated.

Rheumatoid Arthritis

Rheumatoid Arthritis usually begins in the age period of 20-45, but as these people continue to live into the older age group they may often develop signs of a concomitant osteoarthritis—particularly associated with Heberdens nodes in the terminal interphalangeal joints of the fingers. By the time the rheumatoid arthritic reaches fifty-five or sixty, they have usually reached a "burned-out" stage of the disease and their degree of disability has already been established. Occasionally a true rheumatoid arthritis is observed to begin in older people and may run a rapid clinical course.

The indications and contraindications for the use of ACTH and Cortisone in rheumatoid arthritis in the aged is somewhat different than the standards or criteria for administration of these drugs in the younger person. A large percentage of the elderly patients have some degree of generalized arteriosclerosis with a predominance of nephrosclerosis, cerebral vascular sclerosis, and coronary insufficiency, so that the two controversial hormones, ACTH and Cortisone, should not be used except in acute or rapidly disabling rheumatoid cases and only then to be used for short periods of time to get the patient "over the hump" as far as his disability is concerned.

Gout

Gout is still with us but much of it is passing by unrecognized. Part of this difficulty is due

to considerable confusion regarding specific x-ray appearance of gout as it often resembles advanced rheumatoid arthritis. "Punched out" areas that are supposed to be diagnostic of gout are also observed in rheumatoid arthritis. The blood uric acid in gout is elevated in only about 50 per cent of the cases so that the diagnosis is made more on the clinical history of sudden onset of an acutely painful swelling in or around a joint—most often involving the large toe. Ninety-eight per cent of all cases of gout are supposed to be found in males, but modern statistics show that gout in the female is increasing. Tophi are not usually seen until rather late in the disease and occur in only a relatively small percentage of cases.

The treatment of choice in gout is still the old standby drug, Colchicine, occasionally combined with the use of ACTH; the latter hormone being used for a couple of days followed by Colchicine over a long period of time. Butazolidin, a derivative of amino-pyrine, is reported to give excellent results in acute and subacute gout and may even replace Colchicine as the drug of choice in the future. Low caloric and low purine diets are advised during all stages of gout. Benamid is a relatively new drug that is being used successfully in chronic gout. Salicylates are often used in conjunction with Colchicine to stimulate excretion of urates. Physical therapy seems to accentuate the painful symptoms during the acute phase but is helpful when applied to the muscles and tendons above or below the involved joint during the convalescent stage.

Collagen Diseases

In any prolonged illness in elderly persons associated with musculoskeletal difficulties the possibility of one of the collagen diseases being present should be seriously considered. A number of cases of disseminated lupus erythematosus have been picked up because the physician was suspicious of a collagen disease and specific laboratory tests for the lupus erythematosus cell were obtained.

Rheumatic fever is not common in the elderly patient. Scleroderma, periarteritis nodosa and dermatomyositis are occasionally observed in older people and the best clinical means of objective identification of the presence of these diseases is by doing skin or muscle biopsies in questionable cases. Occasionally sarcoidosis is associated with peripheral joint conditions.

Complete Physical Examination

Complete routine physical examination is just as essential in the elderly patient to determine the cause of joint difficulties as it is in the younger group, and the usual laboratory aides to confirm or rule out diseases should be done. In the older person because of the greater frequency of malignancies in the gastrointestinal and genitourinary tract, and in the thyroid and breast, there is always the possibility of bone metastases which may be a primary cause of musculoskeletal pain. Occasionally malignancy is unsuspected until a person is under observation for arthritis, and in a routine x-ray of the spine, shoulders or hips, the evidence of bone metastases is already observed. This factor is particularly noticeable in dealing with severe shoulder pain so that x-rays taken for bursitis of the shoulder or for arthritis of the shoulder should include at least a portion of the upper half of the lung on the offending side, as occasionally a malignancy of the lung is the cause of severe intractable painful shoulder.

Climatotherapy

The elderly person with any type of arthritis or allied diseases seems to improve quicker and feels better in a warm, dry climate where there is a minimum of swings of barometric pressure with a relatively low humidity. Practically all elderly people have some evidence of peripheral vascular deficiency, and this, when combined with rheumatism of any of the weightbearing joints, makes it very difficult for the older person to move around. These people seem to have their greatest difficulty in the morning when they try to get out of bed, at which time they experience generalized muscular and joint stiffness; but after they have been up and walking around for an hour or more they feel much better—probably from the stimulated increase in circulation. If it is at all possible, the elderly person with any chronic joint or muscle disability should spend as much time as possible in a warm, dry climate.

Many elderly patients with rheumatic conditions have varying degrees of anemia and subclinical vitamin deficiency, most of which are due to improper nutrition. When the blood counts are brought up to a higher than average level and the vitamin deficiences are corrected, many of the aches and pains due to fatigue in this group will be lessened.

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Hospital Care for the Chronically Ill

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AUTHORS of textbooks on geriatrics are careful to point out that geriatrics is a study of the biology of the aging process and is not solely concerned with medical treatment of patients in the older age group. From the standpoint, however, of the physician and of the patient, this medical treatment assumes major importance, and medical care naturally involves hospitalization for a large proportion of the patients treated. The problem encountered by patients in the older age group, seeking suitable hospital accommodations, differs from that of other segments of the population only when it involves a long-term stay for chronic disease or disability. It is, then, the same problem which confronts all persons with chronic disease or disability for whom home care is inadequate or unavailable.

At present there are only two general types of facilities providing for the long-term patient; one is the tax-supported—generally county—hospital or infirmary; the other is the group of privately owned and privately operated nursing homes, convalescent homes, et cetera.

The public hospital facilities are available in relatively few counties, and the type of care provided varies greatly. In addition, it is available only to the indigent or medically indigent person. While chronic disease is frequently a cause of medical indigency, the two are by no means always found together; and the benefits now being paid on the basis of age, chronic disability, and from various forms of insurance have made a large additional number of citizens ineligible for care in tax-supported institutions.

The facilities provided by the group of privately owned and operated nursing homes, convalescent homes, et cetera, are meeting some of the needs with varying degrees of success. In general, they provide only custodial care, and in many the cost is prohibitive to most patients and patients' families. Their primary deficiency is the almost complete lack of provision for medical care. There is, therefore, a great need in almost every community for a proper and adequate facility for the long-term hospital patient.

Practically the only solution for this problem, which has been recommended, is the establishment of independent "chronic hospitals." In the writer's opinion, the establishment of such "chronic hospitals" would be a serious mistake and would be a backward step in any sound hospital program. It has for some time seemed to be generally agreed that specialty hospitals have proven inadequate and undesirable because of the inability of hospitals so equipped and so staffed to provide all of the diagnostic and therapeutic resources necessary for the treatment of a single disease process, to say nothing of their inability to provide adequate facilities for any other disease process certain to occur during the period of any long-term hospitalization. If, then, there is a definite need to improve and expand the provisions already in existence for the in-patient care of the chronically ill, and if the concept of the separate or independent "chronic hospital" is to be rejected as unsuitable, what can be proposed to provide the needed facility properly?

Fortunately, we do not have to speculate. This has already been done in several public or tax-supported hospitals by creating within the hospital separate facilities with segregated costs, and by transferring patients from one cost center to another as the need for diagnostic and/or therapeutic procedures indicates. Under this system, the patient remains in the lowest cost center appropriate to his needs except when receiving special services, and his hospital cost is, therefore, kept at a minimum. To illustrate, at the Wayne County General Hospital there are eight cost centers as follows: Ambulatory Indigent; Infirmary Bed Patient, chronic; Out-Patient Department; General Hospital, chronic; Psychiatric, regular; Psychiatric, tuberculosis; General Hospital, tuberculosis; General Hospital, acute. In this and similar hospitals the patient's record is continuous, and his total treatment co-ordinated. Most important, however, is the fact that patients are not admitted to chronic hospital centers except through the acute hospital center, and then only after it has been determined that further treatment can be carried out in the center to which he is to be transferred. This system evolved from necessity, it having been determined by experience that it was impossible to provide proper patient care in a chronic hospital,

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either for physical or mental illness, without the provision of an acute hospital facility. The number of patients who seek admission to these chronic hospital centers on the basis of availability of acute hospital services, which they have been unable to find in other chronic hospital facilities, is significant.

To provide an equally satisfactory program for the long-term patient, not eligible for admission to a tax-supported hospital, it is proposed that the voluntary or privately operated hospital establish a similar pattern by adding to its already existing, excellent acute hospital facility two cost centers, one for the long-term chronic patient and one for the patient requiring purely custodial care. The hospital organization would thus be divided into four cost centers with functions as indicated.

Cost Center No. 1.—Out-Patient Department

Functions:

A. Present out-patient services

B. Post-hospitalization services

C. Pre-hospitalization services preliminary to admission to any one of the other three cost centers, if necessary.

Cost Center No. 2.—Acute Hospital

Functions:

In-patient service for all patients requiring the equipment and staff facilities provided by a short-term hospital regardless of the acute or chronic nature of the illness.

Cost Center No. 3.—Chronic Hospital

Functions:

Bed or bed and ambulatory care for patients requiring a minimum of nursing and medical care, with added emphasis on recreational, occupational, and rehabilitation services and procedures.

Cost Center No. 4.—Custodial Hospital

Functions:

Bed care for patients unable to provide necessary nursing care in a home situation.

These cost centers could be provided either in the same physical plant or in separate pavilions or buildings. It would seem obvious that such a coordinated program of patient care, with uninterrupted professional supervision, would be the lowest cost and most adequate method of providing total hospital services.

It is not anticipated that voluntary hospitals will be particularly interested in expanding or modifying their facilities and organizations in this way, being traditionally concerned with providing only so-called acute or short-term care. In spite, however, of the attempt of all voluntary hospitals to limit their facilities to short-term care, there are undoubtedly at all times patients in such hospitals receiving care which could properly be given in what I have indicated as Cost Centers No. 3 and No. 4. The establishing of such cost centers, and the transferring of these patients to them would be of great financial advantage to the patients or to insurance carriers, and would release much needed bed space for other patients.

At the present time public hospitals are being pressed to expand in order to provide needed services for the population, even for financially ineligible patients; and small private facilities, with inadequate provision for total care, are increasing in number and are attempting to cover a larger portion of their patients' total needs. Unless private or voluntary hospitals enlarge or modify their facilities and adapt their organizations to provide care for the long-term patient in some such manner as outlined above, they will fail to fulfill their obligation to the community from which they derive their support and will fail to keep hospital care in the hands of those best able by training and experience to provide it, and on its traditionally independent basis.

WAYS TO HEALTHIER AND HAPPIER OLD AGE SOUGHT

Ways to more fun for old people as well as better health, jobs and fewer economic problems will be sought in a new broad program to be started soon at the Harvard School of Public Health with the aid of a $112,688 three-year grant from the W. K. Kellogg Foundation of Battle Creek, Mich.

Because the Harvard School of Public Health feels that there are important relationships between all of the forces which affect the lives of the aged, it welcomes the opportunity to help pioneer an approach to the problems of old age that takes into consideration all of the social, economic and health factors with which the older person must contend, Brig. Gen. James Stevens Simmons, U.S.A. (ret.), dean, said in announcing the new program.—*Science News Letter*, March 28, 1953.

Some of the Problems Encountered in Setting Up a Rehabilitation Center

By Frederick C. Swartz, M.D.
Lansing, Michigan

A FUNCTIONAL PLAN for the establishment of a community rehabilitation service and center was presented in 1946 by The Baruch Committee on Physical Medicine. This is an excellent guide and should be studied by all interested in setting up such a center. In the application of such a plan to any local situation, however, many problems arise. It was thought that discussion of these problems might prove interesting.

In Ingham County, as elsewhere, interest in rehabilitation was stimulated greatly in the years immediately following World War II. Several members of the Geriatric Committee of Ingham County Medical Society became so vocal that this problem became the main interest of the committee. Books and pamphlets on the subject were accumulated and several members of the committee paid extended visits to a number of the more prominent rehabilitation centers. One of the recommendations of the Fourth Annual Conference on Aging held at the University of Michigan was that there should be a center in each county for the dissemination of knowledge about the techniques of rehabilitation and that in most cases this could well be in the county hospital. As a result of the accumulation of the above materials and ideas, and after much discussion it was agreed that the goal of a rehabilitation center was not only "To achieve the maximal function and adjustment of the individual and to prepare him physically, mentally, socially and vocationally for the fullest possible life compatible with his abilities and disabilities" (The Baruch Committee on Physical Medicine) but also to spread the philosophy of the modern concepts of rehabilitation to the Medical Profession and allied interested group and to teach the techniques of rehabilitation to the administrators of acute and convalescent hospitals and to the relatives who are caring for the handicapped in the private home.

The above conclusions were then presented to the Director of Social Welfare for the County, The County Board of Social Welfare, The County Board of Supervisors and the Physician of the County Hospital. All agreed that the idea had merit and we were encouraged to proceed.

It was evident from the outset that a total rehabilitation job would require different training and knowledge than could be found in the ranks of the medical profession alone. Motive would have to be found or instilled in the patient. Relatives and friends, and the community as a whole would have to be educated to a new viewpoint regarding the disabled. All of the hospital personnel would have to be trained to participate in the effort. We found early in our pilot experience study that over-solicitous maids slowed the training program by helping the patient too much rather than allowing them to do the things they were supposed to do. Others undermined the efforts and goal of the rehabilitation group with pessimistic and hopeless remarks and attitudes. The needs for rehabilitation in the special service area around Lansing would have to be studied. Training, retraining and placement of the more completely rehabilitated calls for a specialist outside the field of medicine. The placing and utilization of the partially rehabilitated in sheltered workshops, good will industries, or home-bound industries presented another facet of the problem for which we sought assistance. Because of the newness of the field and the uniqueness of a rehabilitation center in a county hospital, the need for a multi-disciplined research program was accepted by all.

To meet the above needs we had but to turn to one of Michigan's great institutions of higher education—Michigan State College. Members of the Departments of Psychology, Sociology, Social Service, Nutrition and Dietetics, Nursing, Physical Education, and Speech and Hearing were called upon and gave magnanimously of their time and experience. Physiotherapist and Occupational Therapist from the Curative Workshop, The Crippled Children's Agency, and private practice came to our aid.

Next a pilot study was set up consisting of ten patients selected from the Ingham County Hospital census. Complete histories and physical examinations were made out on these patients and Activities of Daily Living Charts were filled out. A graduate student in psychology was employed to study this group for motivation. A male nurse was also employed to carry out as best he could

the program outlined by the medical profession and the physical therapist. A room was set aside and partially equipped as a physiotherapy room. Examining tables, parallel bars, mats and numerous gadgets were accumulated from local sources. A photographic record was made of the patients to be utilized later to measure progress of the work. The members of the Geriatric Committee and the Consulting Personnel from the College and Curative Workshop made weekly visits to the Hospital to direct the treatments.

By the spring of 1952 the soundness of the project was accepted by all concerned with it. The next step then was to try to secure financial backing. It was thought that if we could call the whole effort a research project we might secure help from a national foundation. Much time and effort went into setting up the project along these lines. This failed of accomplishment and by the summer of 1952 all we had to show for our efforts was a pilot study.

A revaluation of the problem in the summer of 1952 presented another concept which we decided to try. The idea was to divide the work of the rehabilitation center into a service function and a research function. The service function was thought of as being immediately helpful to the community and county and its cost should be borne locally. After the service plan gets into operation we expect to set up a number of research problems to be supported by such foundation help as can be obtained.

To test the soundness of the above concepts a meeting was arranged with twenty of the community's outstanding citizens. All the foregoing material was discussed with them. In addition, our concept of the local problem, our resources and our aims were presented.

The Local Problem

The Lansing-East Lansing Trade Center has a population of 187,000 people with four acute hospitals, only one of which has provision for rehabilitation services in the person of one physiotherapist with limited equipment and space. The city of Lansing has become a Special Service Center from a medical standpoint for an area which would conservatively include all the counties touching on Ingham County on all sides except where only a half a county is included. There are eleven acute hospitals in this area, none of which have any rehabilitation features incorporated in their hospital services. The total population of this special service area including Ingham County has a population of approximately 366,000 people.

One of our problems for investigation is to find out how many disabled persons there are in this population center. Applying the ratio of disabled to well-population as found in the study at New Haven, Connecticut, we would expect to find some 44,000 disabled individuals in this area, one-third of whom would be home-bound and one-third of whom would be under twenty-five years of age.

Local Resources

1. The growing and progressive City of Lansing is not only the Capitol of the State of Michigan and the center of a Great Trade Area, but is rapidly becoming a major medical center for a large territory of this part of the State of Michigan.
2. A hospital building of approximately 120-bed capacity which is in a better state of physical repair than most acute hospitals in this area.
3. A County Board of Supervisors and a Board of Social Welfare who are in complete sympathy with the progress and efforts outlined.
4. A unique, active and enthusiastic County Medical Society which has matched the enthusiasm of the Committee on Geriatrics of the Society which has been responsible for the initiation of this program in this area.
5. A great University Center at Michigan State College from which we have drawn help from a number of various departments that touch on the problems.
6. A Curative Workshop which in its first year of existence has made remarkable progress in handling the rehabilitation problem which can be cared for on an outpatient basis and which has certainly broken the ground for the introduction of rehabilitation at the hospital level.

Aims

1. To convert the Ingham County Hospital insofar as possible as the need requires into a Rehabilitation Hospital.
2. To give handicapped persons in our "treatment community" the advantages of the modern concept of rehabilitation. Initially, this group is to be taken from patients in the Ingham County

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A Plan for Living in Later Years

By Harold W. Woughter, M.D.

Flint, Michigan

NEW PROBLEMS in constructive utilization of leisure time have been created by the forty-hour working week, compulsory retirement at age sixty-five and the advancing age of life expectancy. Physicians have noticed increasing numbers of retired men and women visiting their offices with complaints of vague somatic discomforts and uneasiness of mind, conditions traceable in many cases to frustrations from being retired while still actively able to be useful producers. Many have been unable to find a satisfactory substitute interest while others are actually suffering financial destitution, their savings having become dissolved by the inflationary spiral.

Medical men have become aware of the growing practice of geriatrics, but they have also become aware that there are preventive measures in this stage of life as well as in the younger groups. There is a challenge to doctors to step out of their closely knit group of professional colleagues and become community citizens along with their neighbors, the lawyer, bookkeeper, minister and laborer; to plan constructively to receive and aid this older group so that retirement may be a happy relaxing experience and not one to be feared.

Herein is offered a community plan designed to be attractive to people in later life. One that is past the "pilot" stage of experimentation, and has sufficiently justified its existence to warrant consideration.

In 1935, Mr. Charles Stewart Mott recognized the growing need for the community to quietly provide constructive recreational and adult educational facilities to absorb the leisure time of the family group. It was realized that no program for older people could be planned to start on the day of retirement but that interest must be aroused sometimes years in advance with a diversified program in which many "trial runs" could be made. In this way an interest could be so aroused that decisions might be made by the individual before the retirement age concerning a new adventure that would be received with enthusiasm.

The Mott Foundation Program started in 1935 to conduct an experimental, demonstrative program in community needs and services, non-competitive with any other agency. The first year's budget was $6,000. It has now grown to include all ages and professions wherever a stimulus in community interest could be found. For the purposes of discussion only that part of the recreational and educational program that directly affects the geriatric group will be followed. There is no segregation of age groups, the elderly people infiltrate the program according to their interests.

Physical Facilities

It was thought that financial investments should be made in services to the people and not in additional buildings which in themselves might offer barriers. School buildings which were strategically located, publicly owned and publicly maintained were used. They were lifelong institutions, a source of pride and loyalty and as familiar to the community as the home. Their hours of usefulness should not end at four in the afternoon. The aging taxpayer, although he has long since graduated from the P.T.A., still supports this community school.

Administration of the Program

It logically follows that a program housed in school buildings and dealing with recreational and educational projects should seek the teaching profession for guidance. The Board of Education, an established, permanent body, appoints a Mott Foundation Coördinating Committee consisting of three members from the Board and three from the community at large. This committee appoints a director of the program (who in this case is an Assistant Superintendent of Schools) and reviews proposed budgets, plans for continuation of pilot projects and studies suggestions for new community services. The committee reports are reviewed by the Board of Education and when approved the annual budget is forwarded to the Mott Foundation Trustees. The funds received from the trustees are disbursed by the Business Manager of the Board of Education in the same manner as all other funds although earmarked for only those projects set forth in the Foundation's budget.

Dr. Woughter, a member of the M.S.M.S. Committee on Geriatrics, is chairman of the Mott Foundation Coördinating Committee.

Employes

There is a wealth of talent for recreational and educational effort to be found within the school system. However, instructors from practically every field are sought and selected on the basis of leadership, enthusiasm and capability. At present these include professional educators, housewives, tailors, psychologists, storekeepers, doctors, lawyers, artists, salesmen, furriers, chemists, librarians, ministers, radio technicians, interior decorators, home economists, clerks, stenographers, industrial workers, et cetera. In the present program there are thirty-three full-time employes, 282 who participate on an hourly basis and many volunteers.

Activities

Different communities naturally desire different activities. Some develop interest in hobbies, art and literature. Others demand educational programs to aid or augment their income, while some ask for predominence in purely recreational and participating entertainment. If a special program is sought and has the interest of at least ten people, it will be housed and a leader obtained for the length of time the interest is maintained or the course completed.

Some of the most popular activities are listed below:

Upholstering group in Mott Foundation class.

Educational

How to Start a Small Business
Successful Selling
Income Tax Returns
Creative Writing
Bookkeeping
Landscaping
Household Mechanics
Furniture Refinishing
Furniture Upholstering
Woodworking
Chair Caning
Wood Carving
Radio Repair
Auto Shop
Lampshades
Television
Photography
Leathercraft
Carving Cowhide
Dresden Craft
Creative Ceramics
Art Workshop
Water Color Painting
Oil Painting
Lettering and Sign Painting
Knitting
Dressmaking
Tailoring
Millinery
Furs
Slip Covers and Draperies

Recreational

Square Dancing Instruction
Couple Dancing Instruction
Social Dancing Instruction
Contract Bridge
Men's Club
Women's Study Club
Fly Casting
Bait Casting and Spinning
Fly Tying
Community Players
Fit as a Fiddle (health)

Once each year an Arts and Crafts Exhibit is held in one of the school Gymnasiums to which the public is invited.

Enrollment and Fees

Publicity by booklet, pamphlet and the newspaper is issued each year in advance of registration. The year has three sessions, Fall, Winter and Summer. Small fees from $1 to $5 have been charged for certain programs requiring special supplies and to discourage promiscuous enrollment. People who show genuine interest in an activity and feel that the fee is a burden may be admitted free.

Finance

It is not expected that any community would begin a program with a large number of diversified activities. As mentioned above the Mott Foundation Program started in 1935 in five scattered school buildings on a $6,000 budget. It has grown through public interest, of neighbor telling neighbor, until the budget now exceeds $350,000 yearly.

The cost of a program as outlined above, appealing to the older age group, can be financed for less than it costs to operate a medium sized elementary school for one month of the school year.

Conclusion

We are not hesitant in recommending this type of program to communities interested in making the geriatric period of life richer for its people. Nothing has been so gratifying to the workers in the Mott Foundation program* as the occasion of Mr. C. S. Mott's seventy-fifth birthday when the citizens of Flint, Michigan, filled the Industrial Mutual Association Auditorium to the rafters to pay honor to this gentleman, not because of his success in the business world, but because of his foresight in providing community resources capable of making a more abundant life.

*For detailed information, address Mr. Frank J. Manley, Director of the Mott Foundation Program, 529 Mott Foundation Building, Flint 3, Michigan.

SETTING UP A REHABILITATION CENTER

(Continued from Page 512)

Hospital, but with progress these facilities will be made available to private patients.

3. To further develop methods of rehabilitation.

4. To further our understanding of the personality changes involved when people become chronically disabled.

5. To establish a definite training program, using all the different phases necessary for a complete rehabilitation job. We expect to develop a center for the dissemination of information on rehabilitation to all those who are interested and at any level—whether it be an administrator of an acute or convalescent hospital or an individual responsible for the care of a disabled patient in a private home.

6. To do research on the problems of rehabilitation and geriatrics from the standpoint of sociology, psychology, nutrition and many other fields that may contribute something to the solution of the problems. This type of inter-disciplinary collaboration is unusual in scientific investigation and it is our effort to probe the advantages of this type of approach.

As a result of this meeting we have received enthusiastic support of all individuals and groups consulted, to the end that as of February 18, 1953, we have an incorporated Rehabilitation Center in Ingham County, financially supported by the County, and are in the process of adding some paid trained personnel to supplement the work of the voluntary groups.

215 North Walnut Street

The Value of the Periodic Health Examination

By William S. Reveno, M.D.
Detroit, Michigan

MOST OF US who are engaged in the practice of medicine will readily concede the value of the periodic health examination. It is the foundation of sound medical practice from which prevention and treatment stem and on which the most enduring patient-physician relationships are built. While mainly unspectacular, it is highly gratifying both to doctor and patient. It is the one effort in medical practice that is most enduring, least subject to radical change and lends itself readily to participation by the majority of practitioners. In short it is or should be the main professional purpose of every doctor of medicine.

But we are not all of one mind in this respect principally because of the changes that have occurred in the practice of medicine and partly through our own narrowed perspective. In the last half century we have witnessed a decided change in the pattern of deaths. Whereas the doctor was formerly pitted against a wide variety of maladies he is of late fighting either heart disease or cancer in at least half of his patients and heart disease alone is almost one third. Small wonder then that his attention has been centered on these organic diseases and the other seemingly less demanding ailments have been left by the wayside as has the person harboring them.

The factor that has narrowed our perspective is the phenomenal development of therapeutic procedures. I cannot deny that this has been a boon to humanity and shall continue to hope like everyone else for further discoveries. But it must be recognized that our fascination by the near conquest of infectious diseases and the high proficiency attained in surgery threatens to make mere technicians of us all. This would not be so bad if we had cures for most ailments but not having reached Utopia our concentration solely on the curative cannot but promote atrophy of the other attributes that are essential in a good doctor.

Our preoccupation with curative medicine has not escaped the notice of alert observers in the public health field. The vacuum created by our interest in therapy has generated a movement that can type us for but one part in the program of keeping people well. This movement that started with mass blood testing for syphilis, chest x-rays for tuberculosis and urinalysis for diabetes is even now elbowing its way into medical practice with the introduction of screening procedures for obesity and hypertension, and is waiting watchfully for the opportunity to invade areas we have seemingly staked out but are not working. Thus our efforts, aimed mainly against government to thwart entry of third parties into the practice of medicine, may be neutralized and the fight lost to another adversary by default.

If there is merit in our present system of medical practice and it is worth extending and expanding then we must take an accounting periodically to keep it on course. Side explorations into specialization, and, of late years, into therapy, are essential to our development and increasing usefulness but for too many of us to tarry too long in any of these ventures is to estrange ourselves from our patients and lose both face and place in the process.

There is then good reason for us to broaden our viewpoint so that we will become concerned with more than just treating or curing the patient of his presenting ailment. We must not be content with lancing a boil, removing a wen, prescribing a cough medicine, ordering a cathartic, suppository or douche or giving a "shot" of liver or penicillin because it saves us time to see more patients for whom to do the same things. Let us rather learn as much as we can about each of our patients, developing an awareness of their physical and mental potentials so that we may treat them more intelligently and protect their health and well-being more effectively.

Now I grant that all of this takes time and you will say that the demand is so great that we cannot do more than touch the high spots. There is but one answer to this weak defense. The patient deserves and expects undivided, earnest attention even though he may seem in a hurry; and we are short-changing him if we offer him anything less. To give the patient what he needs, not alone what he wants, we must discipline ourselves to become more thorough and we must allocate our available time more efficiently. Treatment of the presenting symptom or complaint should be regarded as a temporary or holding measure with a plan ready for the complete evaluation of the whole patient at the first reasonable opportunity.

How shall the periodic examination be carried out, how detailed must it be, and what facilities are necessary for its performance?

It would be presumptuous for me to tell the experienced practitioner how to conduct this basic procedure that he learned years ago in medical school. My only reason for taking your time with its details is that so many of us have through the years cut so many corners that it remains but a token gesture.

A detailed history is of the utmost importance. The time spent in its development pays good dividends. Not only does it elicit the subjective evidence for a proper diagnosis but, what is most important, it offers the opportunity for effecting a close relationship between the patient and doctor. Here there is a meeting and reading of minds so essential for a proper determination of what is troubling the one and the capacity of the other to understand. A skillfully conducted interview sifts out irrelevant material, provides essential background for a solid future relationship and comes up with a correct diagnosis 50 per cent of the time.

The gathering of objective evidence through the physical examination need not take nearly as long as the history. Here it is essential to leave nothing to the imagination and the examiner must discipline himself to cover the whole body systematically. Routine weight, height, temperature, pulse and blood pressure, a survey of the body build, inspection of the skin for discoloration, scars, change in texture, eruptions and hair distribution, and palpation for enlarged lymph nodes should come first. Then examination of the skull and scalp, the facies and the eyes, including a look at the fundi. The ears should be tested grossly for deafness with a tuning fork and the auditory canals investigated with the otoscope. In the nose the condition of the mucosa, the position of the septum and the presence of polyps should be determined. The mouth deserves close inspection under good light so that the entire mucosa (even that under dentures), the tongue, the teeth and the pharynx may be inspected. The parotid and sub-maxillary glands should be palpated as should the thyroid gland for size and consistency.

Despite the accuracy and indispensability of the x-ray it is still highly worthwhile to inspect the chest, looking for abnormal movements and pulsations, then mapping out the heart borders and the apex and percussing the lung fields thoroughly. The female breast should be thoroughly examined for change in texture, tumors and discharge from the nipples. Auscultation should be done not only to show the patient that we own a stethoscope but know how to use it—over the bare skin. Most of us have come to lean so heavily on the fluoroscope and x-ray that we have lost the ability to use our own senses in evaluating the heart and lung sounds. We order an x-ray first then corroborate the findings afterwards. Like doing a problem in arithmetic by looking up the answer first. When the x-ray isn't available we're lost.

The methods for examination of the abdomen are much less exact than those for the chest so that reliance must be placed mainly on inspection and palpation. The contour, abnormal movements, visible peristalsis, scars and distended veins may be noted at a glance. Palpation then can determine the presence of pain, tenderness, spasm, the texture of the abdominal wall and the presence of tumors, masses and enlarged viscera. Hernia, epigastric, umbilical, incisional, inguinal and femoral, should be sought in both male and female.

The male genitals may present hypospadias, ulcers, herpes, scabies, warts and fungus infections. There may be a scrotal hernia, an undescended testicle, epidydimitis, hydrocele and tumors of the testicle.

The female genitals may show skin lesions, urethral caruncle, urethral and vaginal discharge, cystocele, rectocele, perineal laceration and fistulae. Bimanual examination should be made for position, size and consistency of the uterus as well as changes in the tubes and ovaries. Inspection of the cervix by speculum under good light must always be carried out and the possibility of malignant invasion ever kept in mind. Suspicious areas warrant prompt action either by biopsy, study of scrapings incorporated in a piece of Gelfoam by the Gladstone technique, or examination of the Papanicolaou smear.

In the rectal examination one should look for hemorrhoids, fissures, fistulae, prolapse of bowel, ulcers and condylomata. Digital examination will reveal sphincter tone, stricture, polyps, hemorrhoids, tumors and the condition of the prostate and seminal vesicles.

The extremities and joints present readily evident changes such as edema, varicosities, fungus infection, deformities and vascular disturbances.

An observation often neglected is palpation for the femoral, popliteal, posterior tibial and dorsalis pedis arterial pulsations.

In the past, examination of the spine has usually been left to the osteopath or chiropractor who have made capital of the opportunity, jeering at us for our neglect. Inspection for deformities, limitation of motion and muscular atrophies, and palpation for tenderness and spasm take little time but may yield valuable information.

The neurological examination throws most of us for a loss. For practical purposes it should include testing the cranial nerves, motor function, the superficial and deep reflexes and sensation. The mental state can be evaluated at least grossly during contact with the patient at the general examination.

Now it has taken me much longer to describe what may seem to be a discouragingly large number of observations than to make the tests and note the signs. Actually few patients will present more than one significant abnormality, or at most a few. More important is it that the absence of many of the pathological conditions can be rapidly determined and a thorough examination completed in most instances in a surprisingly short time. If you familiarize yourself with the procedure and follow a definite plan, remembering what may be found and being alerted for it, you will rarely sell yourself short through omission.

Whatever the excuse may be for not doing a complete examination, it is far outweighed by the yield resulting from its performance. For example, a long standing blepharitis may be explained by an overlooked seborrhea of the scalp; a persistent throat irritation or cough caused by impacted wax in the auditory canal; a facial neuralgia from an unerupted third molar; endocervicitis; cervical malignancy, ovarian cyst so foreboding in the woman over forty, testicular tumors, pruritus ani caused by fungus infection transmitted from the feet, and peripheral vascular disease by absence of arterial pulsations in the feet. All of these point to the same precept: if you don't seek you won't find; and seeking constantly with a high index of suspicion is vital in the search for abnormalities.

What about laboratory procedures?

It is best to keep these at a minimum, using them after, not before the examination has been completed. Too many slot machine diagnoses are made by substituting batteries of tests for what may be more clearly seen by an alert examiner. Our diagnostic efficiency has been hampered in many instances by overdependence on the laboratory and we find ourselves quibbling over decimal points while the clinical picture is trying desperately to give us the answer we seek. Many of us have become so imbued with what the laboratory offers that we will not venture into the open without making certain that its complete facilities are available. It is not my purpose to belittle this facility but to emphasize its proper use as a supplement to our five senses and the clinical acumen which these supply for us.

Looked at in this light the laboratory procedures divide themselves into two groups—those that are essential to every diagnostic work-up, the simple tests, and those that are to be invoked in running down a particular clue.

The simple tests are readily available to all of us and are best done under our immediate supervision. These consist of a urinalysis, stool examination for ova and parasites and occult blood and a complete blood count. A blood Kahn should be done on every patient, facilities for its performance being accessible to everyone. A simple glucose tolerance test can be performed with a specimen of urine obtained two hours after a rich carbohydrate meal. Kidney function may be evaluated by specific gravity determinations on urine specimens after a day of abstinence from fluids and after abundance of fluids for a similar period—the so-called concentration and dilution tests.

Gastric contents, sputum and urethral and vaginal smears present no great technical problem to any of us.

The remainder of the laboratory tests belong in the realm of special procedures—not to be invoked for window-dressing but only when clearly indicated.

X-ray study of the chest is a highly valuable supplement to the examination and should be included if at all possible. It represents a wiser expenditure for the patient than do many of a long list of impressive laboratory procedures. Other roentgen-ray studies are of course to be made only when indicated.

Having completed the survey and summarized it the final step is to impart to the patient the findings and the implications. It is not enough to tell the patient he's O.K. and to let it go at that. He's quite liable to feel that a lot of his time and money have been spent to discover something he

knew all along. Nor is it fair to hit him between the eyes with a diagnosis and prognosis that stands to change his mode of life abruptly. The average patient will accept thankfully information about himself that is shared with him as a full partner. Our obligation is not fully discharged unless we take the time to talk things out, giving the patient the opportunity to ask questions.

How much should an examination cost?

Quite obviously the cost should be neither prohibitive nor punitive. If we attempt to market our product at too high a price few will be able to buy it and the public demand and need will either not be met at all or filled by shady opportunists or the government. Neither can we afford to be high-handed or punitive in our demands for that is the surest way to estrange our patients. A fee based on a fair return for time spent is the most equitable approach to the problem.

Assuming that it will take an average of one hour to complete the study and from four to six patients can be seen ordinarily during that period at a fee of $3.00 each then the fair charge would be from 12 to 15 dollars. If the fee per patient visit is higher the cost would rise in proportion. An additional charge of from 5 to 10 dollars for the routine laboratory studies would be added making the total cost between 17 and 25 dollars. Should special laboratory procedures be indicated, their costs—at current rates—would constitute an added charge.

Now this may appear to some to be too high a figure but the complete package that is offered comes to grips with the patient's problem at once, eliminating, as it should, many visits during which only presenting symptoms are shut off or "needled." Few patients will fail to sense the saving in time and money nor to appreciate the merit of the service being rendered.

Is the public sold on the periodic health examination?

Any of us who doubts that there is a growing widespread demand for this type of service needs only to count the thousands having blood tests for syphilis, chest x-rays for tuberculosis, urinalyses for diabetes and examinations to detect cancer. Life insurance companies have been promoting the cause for years and lay writers in newspapers and magazines are beating the bushes for us so that there is hardly a person who is not acquainted with the idea. The sick are of course interested in getting well but the well are interested in staying well and they depend on us to do the job.

In recent years, management, recognizing the sizable investment in its executives, has insisted that they have annual health examinations and the move has paid off in healthier, more efficient workers. Among 575 men examined in one year for a large corporation there were twenty-six with duodenal ulcers; fifty-one with hypertension; twenty-nine with generalized arteriosclerosis; six with coronary heart disease; three with angina pectoris; twenty-eight with prostatic hypertrophy; four with early pulmonary tuberculosis; thirty with arthritis of the spine; eight with diabetes; thirty-seven with obesity; and forty-eight with anxiety, tension and exhaustion. A total of 802 abnormalities were disclosed, most lending themselves to correction.

Similar experiences have been recorded with other groups—all adding up to the same lesson: complete examinations repeated annually disclose defects when they are easiest to correct. Result: high yield on the investment to the whole community. Certainly the public doesn't need to be sold!

To meet this burgeoning demand squarely we will have to realign and broaden our practices to include all people, the well and the ill, the whole person, not just the part that is ailing. We will have to recognize that preoccupation with the curative phase of medicine must make technicians of us all relegating us to a remote corner in the health field and separating us from the commanding position we now hold.

We thus have in the periodic health examination a priceless tool with which we may serve people better and keep the practice of medicine paramount. If we neglect this opportunity we will have only ourselves to blame as others take up what we have abandoned.

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The Social Impact of Longevity

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THE POPULATION of the world is increasing at a rapid rate. This increase has become much more evident during the past fifty years than ever before in the history of man.

A remarkable decline in mortality accompanied by a fairly constant or slightly declining birth rate has changed the old balance of population. Many more persons are surviving more of the hazards of life and live to a greater age than ever before.

The basic life span probably has remained unchanged, since we always have had an occasional individual who lived to be one hundred years of age. But infant mortality, young persons dying from the acute infectious diseases, accidents and wars heretofore have kept the average age at death rather low for thousands of years. During the past fifty years infant mortality rates have been going down quite rapidly; many acute infectious diseases of childhood are no longer epidemic; accidents and wars still kill a great many persons but of the total number injured a much higher percentage of them are rehabilitated than ever before.

Late birth rates are about forty per thousand and death rates are dropping to fifteen per thousand resulting in an annual increase in population of about three per cent, a relationship already established in quite a number of nations. Within the foreseeable future, the world's population will be increased every year by about 38 million persons.

Average life expectancy in the United States has increased from about forty-six to sixty-eight plus during the past fifty years. The number of persons over sixty-five in our population has been increasing rapidly.

1900.....	2,000,000	
1940.....	9,000,000	
1950.....	12,000,000	
1975.....	25,000,000	(estimate)

Life in the United States has been changing appreciably during the past few decades from a young toward an older society and this trend will be more noticeable in the future.

A child born in 1953 has some chance of living to be one hundred years of age, assuming that he escapes death by violence, or perhaps we should say that a greater proportion of the children born in 1953 will live to approach one hundred years than ever before in human history. Small credence should be placed in prospects of a life span of one hundred fifty years.

An important trend in present-day living is the conspicuous shift of population from the country to the city. In 1800 six per cent of the people of the United States lived in urban areas. Today sixty-three per cent of the population lives in the city. This rural-urban shift has had a significant effect on the social problems of the aged. Farm houses in the old days usually were large and could accommodate aged parents or grandparents without too much trouble. Agricultural employment was of such a nature that an elderly or slightly infirm person could perform a number of useful tasks until very late in life. Another factor was that there were more children in the farm family some of whom could be detailed to care for grandma or grandpa. All this was before the automobile, the farm tractor and birth control invaded the country.

Contrast this with contemporary urban life. The high cost of building has made most new houses small; five rooms is about the average. There is really no place for oldsters to live with their children. Urban occupations are such that an individual is employed either full time or not at all. It is a little like being sick in the army where a soldier is either a patient in the hospital or he is on full duty. The city family has fewer children to share the duty of caring for aged parents. In general, urban culture is such that its god is efficiency and the infirm and the aged are cast aside irrespective of the social and mental loss occasioned by this technologically efficient method of doing things. And I believe that this situation will be intensified in the future.

As older persons become an increasing proportion of our population, they may influence the political situation because it is evident that they will have in their hands a greater voting power than ever before. It may even come to pass that their votes will be a major factor in some future election.

Some possible implications of this are: first, those elected to political office may in general be older, for usually older persons tend to vote for older candidates; second, if older persons control

the vote, they may well force legislation favorable to some wild or irresponsible scheme for promoting large pensions or other forms of assistance to the aged; and third, as our population ages, our political conservatism in national and international affairs will be more pronounced.

One of the most far-reaching of the social psychological effects of aging is occasioned by loss of employment on the part of older persons, especially those who have worked hard during the major part of their lives. Forced retirement often imposes a great hardship on a man or woman accustomed to work. The suddenly retired person does not know what to do with himself, and idleness soon leads to degeneration, both mentally and physically.

Some form of avocational training must be introduced. It should be introduced before the day of retirement so that the elderly person may develop an avocational interest and does not have to explore a planless future for something to do.

Another important aspect of the social psychology of old age is to understand the period of readjustment that comes when a person's wife or husband dies. It is not only the loss of a mate but friends and relatives as well that cause an older person to become despondent. Other interests must be brought into such a person's life to help make up for the loss of lifetime companions.

I think that it might be a good plan for all of us to cultivate a large circle of friends against the day when they pass away one by one. I think that it might be a good plan for all of us to cultivate a large number of intellectual pursuits other than our regular work against the day when that too may be taken away.

Consider for a moment the life of an individual who goes to school, concentrates heavily on one subject, paying no attention to anything else, getting to be a professor and teaching the same subject without variation for forty years to the exclusion of other matters that can be part of life.

Contrast this with a man, let us say, who is born and raised on a farm, goes to school and on to a professional college, serves as intern and resident, spends a couple of years in the army, one year in France, works as a doctor of medicine for many years, but all the time is interested in a variety of pursuits such as: stamp collecting, radio building, literature and book collecting, writing, photography, collecting several forms of the fine arts and becomes almost professional in a variety of these fields. Such an individual may seem to have lived many lives, or stated another way, is young again every time he embarks on a new enterprise.

The general practitioner of today is finding that a gradually increasing number of his patients are in the older age group and this trend will continue. Furthermore it seems quite natural and logical that these older persons should become the patients of the doctors of general medicine. It has been suggested that the study and treatment of the aged should be a particularly suitable province for general practitioners.

Leaders in this comparatively new field of medicine, geriatrics, are studying the aging process in all of its various ramifications. This study seems to reveal what many physicians have thought for a long time, namely, that senility is not a disease entity, that the aged patient does not die from senility, but from one or more frequently several of the diseases well known as causes of death since time immemorial, including, as always, acts of violence, accidents and war.

But the primary question as to why the aged patient is more susceptible to certain diseases or certain tissue changes and eventually succumbs to some infirmity remains almost as obscure as some years ago, except that we know that the renewal of cells in the body does not take place as rapidly in age as in youth; in fact, some cells never regenerate, such as the brain cells.

The achievement of old age is not entirely an unmixed blessing. Longevity seems to be fine on an individual basis, the way physicians look at the problem, but twelve million to twenty-five million oldsters are bound to alter the American economy and, unless handled with considerable foresight and some intelligence, can upset the economic equilibrium as much as dust bowls and locust waves have in the past.

That old age has become of economic concern to the citizenry of the United States is revealed in the numerous pleas for various pension plans to help people in their later life.

Currently out of the twelve million now over sixty-five, about ten per cent receive their primary support from investments, annuities or other returns on personal thrift, or good luck in inheritance bequests; another thirty per cent depend upon Federal Old Age and Survivor benefits; and twenty-nine per cent upon Old Age Assistance program. Some seven and one-half per cent get

along on pensions that they earned while employed by commercial firms; while six and one-half per cent rely on pensions from their former jobs in Federal, State or Municipal service. The remaining seventeen per cent simply are not covered.

It is very evident that today's rising living costs put a severe strain on all persons whose earnings are cut off at age sixty-five.

Such a circumstance seems arbitrary and unreasonable. Every physician has personal knowledge of a great number of persons who are physically and mentally competent to continue their work for ten or fifteen years after their sixty-fifth birthday, while others of course have become infirm long prior to that age. Employed people are much happier than idle ones and incidentally they continue to live longer. It is a most tragic waste of resource to the family and a lamentable loss to the national economic community to permit persons with developed skills of various kinds to become unproductive. Experience and wisdom should be listed among a nation's most valuable assets.

While it is true that heretofore in America we have placed much emphasis on youth and speed and mass production, nevertheless, with life expectancy being extended almost daily, this approach to retirement will have to be revised drastically and older persons retained in productive employment, otherwise the increasing nonproductive members of our society will constitute such a burden on the productive segment that crises will occur continually in food supply, in housing and in the whole pattern of life and its economics.

The old pattern of Youth, Middle Age and Retirement is incompatable with modern society. A new cycle of life is in the making.

Let us learn all that we can about the aging process.

Let us take care of these older persons.

Let us act as adviser occasionally on family problems that may be outside the field of medicine.

Let us be very efficient in determining the causes of their infirmities but above all let us be kind and considerate to them because sometimes all that we can offer in diseases like advanced cancer and arteriosclerosis in the aged is kindness and surely they deserve a little consideration in their last days.

THE PROPER EXAMINATION OF AN OLDER PERSON

(Continued from Page 502)

One of the worst mistakes we can make after we have examined an older person is to assume the attitude of indifference just because there is no major disease present, pass him off with a remark that, "With a physique like that you will live to be ninety." The aging person is looking for corrective treatment where indicated. He wants advice concerning his work, how much and how long should he work? How much golf should be play? The admonition to "take it easy" means nothing. He is looking for corrective advice and definite instructions and re-examination at stated regular intervals.

The treatment of an acute pathological condition or the surgical removal of a diseased organ is a necessary part of advice, but the advice and consideration we give to the total problem of the aging person depends on the care with which we have examined the patient and interpreted any defects in the whole life of the person.

Summary

1. The total examination of an aging person was discussed, pointing out the necessity for evaluation of all of the related problems.

2. The biological ages and changes which occur in them were discussed.

3. It was shown how functional changes affect the age of a person.

4. The proper examination must include advice for the prevention of disease, as well as setting suitable time for regular periodic re-examinations.

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Upon Considering My Age

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*Now Is The Prime Of Life**

Old age is new, Yet, further on,
Man's life has nought to do with time.
"When youth is gone, why linger on?,"
Ask swaddled babes not free to climb.

"What *is* old age?," the youngster cries
Who sage and age has yet to try.
"Just fuller measure," Age replies,
"We ply our youth until we die."

Most sickening of creeds outworn
Illusion Time palsies our will,
Devouring life as soon as born.
Help NOW the myth of Time to still.

"Past" and "Future" cannot own us.
NOW holds the only life of "When"
And can heal the hurts that Chronos
Brings on humanity with "Then."

Time's toll in human sacrifice
The present moment can restore.
Soul heal in this deep insight lies:
Man worthy NOW and nevermore.

Only the Present Age can tingle,
NOW gives Eternity its sense.
The nostrum in this little jingle
Holds life's law: To live, commence!

OLD AGE is the very first subject treated in Plato's principal work, "The Republic." Socrates, the narrator, inquires of the aged Cephalus: "Is life harder towards the end, or what report do you give of it?"

"I will tell you, Socrates, he said, what my own feeling is. Men of my age flock together; we are birds of a feather, as the old proverb says; and at our meetings the tale of my acquaintance commonly is—I cannot eat, I cannot drink; the pleasures of youth and love are fled away; there was a good time once, but now that is gone, and life is no longer life. Some complain of the slights which are put upon them by relations, and they will tell you sadly of how many evils their old age is the cause. But to me, Socrates, these complainers seem to blame that which is not really in fault. For if old age were the cause, I too being old, and every other old man, would have felt as they do. But this is not my own experience, nor that of others whom I have known. How well I remember the aged poet, Sophocles, when in answer to the question, How does love suit with age, Sophocles—are you still the man you were? Peace, he replied: most gladly have I escaped the thing of which you speak; I feel as if I had escaped from a mad and furious master. His words have often occurred to my mind since, and they seem as good to me now as at the time when he uttered them. For certainly old age has a great sense of calm and freedom; when the passions relax their hold, then, as Sophocles says, we are freed from the grasp not of one mad master only, but of many. The truth is, Socrates, that these regrets, and also the complaints about relations, are to be attributed to the same cause, which is not old age, but men's characters and tempers; for he who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition youth and age are equally a burden."

Of all of the psychological treatises on senescence this writer has found, Emerson's essay entitled "Old Age" stands out as most superior, even to Cicero's *"De Senectute."* Among other profound insights he observes: "When life has been well spent, age is a loss of what it can well spare, —muscular strength, organic instincts, gross bulk, and works that belong to these. But the central wisdom, which was old in infancy, is young in fourscore years, and, dropping off obstructions, leaves in happy subjects the mind purified and wise. I have heard that whoever loves is in no condition old."** Past sixty he corroborated his earlier views that mental material never lost its youth, "Within I do not find wrinkles and a used heart, but unspent youth." We are reminded of Goethe's self-observation, "Age does not make us childish, as some say; it finds us true children." That man never grows senile who keeps access to the child in his make-up. Free imagination, comprehensive kindness, and extensive recognized self-experience are essential to the development of the whole physician as of the poet. "Fed on the dry husks of facts, the human heart has a hidden want which science cannot supply; as a steady diet it is too strong and meaty, and hinders rather than promotes harmonious mental metabolism. . . . To keep his mind sweet the modern scientific man

*Old verses from the writer's hoary mind.

**Medical educators recognize the important distinction between "senility," a misleading term, which applies to the disorders occurring in advanced years, and "senescence" which credits a man of advanced years with his full health significance. Careful investigations in senescent people disclose no pathology.

should be saturated with the Bible and Plato, with Homer, Shakespeare, and Milton."† It is true that in certain of us human beings it is very difficult to observe that age does represent power and wisdom. We might have to quarry for it, but we would certainly find the poet in every one. Of most of us we may have to sing with Thoreau:

> "My life has been the poem I would have writ,
> But I could not both live and utter it."

A few plain questions. How many are the days of the years of thy life? What is the best meaning to attribute to the idea, to come of age? How much have we been aware of living our own life? When is our turn to do our own dying? Have we recognized that life for us is about us? Are we really old at all until we find our several selves?

This matter of having so many more of us able to die a so-called "natural death" than ever before, has created a very acute situation, not only in our hospitals but elsewhere in our communities, especially in our homes.‡ In our own home many of us have had the care of one or even two of our parents over a period of many years and are thoroughly familiar with the statement that it is very difficult for two families to live under the same roof. It is difficult, yes, but let us ask what we have ever found worthwhile in our life of which we have been unable to observe, "It was hard, was difficult, while undertaking it." "A nation cannot last half slave and half free." Let us use Lincoln-like integrating insight and ask if a nation can last if one important fraction of it is being neglected, and the rest "apparently" taken care of. During the past year this writer was called in consultation with an able internist caring for an octogenarian patient who, while under hospital treatment for a fracture, seemed to be entering upon a mental, including general physiological, collapse. Only when visited by her daughter did she "brighten up" temporarily. Renouncing a suggestion that the patient be transferred to a more cheerful and home-like hospital, *another strange place,* she was instead returned to her home where in her beloved surroundings she enjoyed recovery best described as sudden. Her internist observed that through this demonstration he became more than ever "converted" to the efficacy of psychological medicine.

There is a surprising need to dispel certain popular illusions around the true meaning of growing old. A first one identifies aging as getting ready to die. Thoreau noted, only ill cared for men grow hard. "It is a result of despair, this attitude of resistance. They behave like men already driven to the wall." For all of us who are in advanced years the few remaining years of living are the most important and cherished of all. The older we become the less apt we are to misprize the life left us, and this life-loving insight is one of the very greatest advantages of a healthy senescence. It does seem most probable that "old age," as popularly conceived, is indeed a very premature condition brought upon us by disinterest in living.

> It is too late! Ah, nothing is too late
> Till the tired heart shall cease to palpitate.
> Cato learned Greek at eighty; Sophocles
> Wrote his Grand Oedipus, and Simonides
> Bore off the prize from his compeers,
> When each had numbered more than four score years,
> Chaucer, at Woodstock with the nightingales,
> At sixty wrote the Canterbury Tales;
> Goethe at Weimar, toiling to the last
> Completed Faust when eighty years were past.
> These are indeed exceptions; but they show
> How far the gulf stream of our youth may flow
> Into the arctic regions of our lives . . . .
> For age is opportunity no less
> Than youth itself, though in another dress,
> And as the evening twilight fades away
> The sky is filled with stars, invisible by day.*

If we wish to observe every age as a developmental era preparing for death, and live within this shadow of our numbered days from the very beginning, all well and good, but singling out the last years of the human being's life for that particular purpose is one of the greatest inhumanities. Emerson has observed how easy it is to confuse the aging process with such masks of age as dim vision, loss of hearing, gray hair; the real essence of age being intellect. Becoming older is essentially having hived up accumulative self-experience. The tremendous wisdom of old people is very inadequately mobilized, due at least in part to the fact that the senior *appears* to separate off from

†Sir William Osler, *Science and Immortality.*

‡Now 12,000,000, or one in thirteen of us, are over the age of sixty-five years. By 1980 it is estimated conservatively that over 40 per cent of the population of the United States will be over forty-five years of age. At the present time 27 per cent of our United States population are over forty-five years of age. The life expectancy of the average Roman or Greek citizen was somewhere around twenty-five years; of the American during our revolutionary war period, around thirty-five years; of the United States citizen 100 years ago, forty to forty-five years; of the United States citizen today, sixty years. It is well to have greatly in mind that such statistics as these are misleading to all who are not aware that the most of us old people are able to take care of ourselves often better than we could when we were younger.

*From Longfellow's *Morituri Salutamus.*

his peers and juniors through gaining ultimately a clearer view of his own integral supreme importance as a human individual. As Christian Gauss has reminded us, let us understand fully the difference between individual and individualist. The individual receives from others and bestows upon others with only gain to self; the individualist subtracts from others with only loss to self.

How can we further ourselves along the democratic direction to mental health eminence? What is big and what is little? How shall we lead ourselves? In nothing have we so strong an interest. We beware the man who finds his happiness in telling others what to think and do. For seeing how we shall lead ourselves mentally, let us observe mental health distinctions. The well mind is distinguished especially by these two necessities: (1) to protest against the "doing others' thinking for them" hypocrisy and (2) to observe for one's self. Of all self hurts there is none more purely vicious than his who employs vigor to keep down the individuality of his less favored fellow creature. Doulocracy! The mentally well man knows that he has all that he can do in being the agent of god *to himself*. The mentally sick man cannot know that of all kinds of misfortune, misbehavior is the worst kind, that an ill manner is the worst form that illness can take. There is but one rank that makes for friendly communion rather than a sense of injury, and that is the rank of honor, never conferred, ever earned by enduring more and more of our onefold human nature.**

A second illusion confuses simple addition with subtraction. "Old" does not negate "young," but includes it. When we get to be twenty-five, thirty-five, forty or fifty years of age, there is a strong tendency on our part to feel that this means we are Tithonus like, no longer one-year olds, two-year olds, three-year olds. If we are on the fiftieth floor of a building, all of that does not mean that the sub-structures are unimportant, including the ground on which the building rests. Cicero treated this aspect, "For as I admire a young man who has something of the old man in him, so do I an old one who has something of a young man." No matter the age, it is chiefly the little helpless child who benefits from our medical presence and offerings. Seeing the wonderful infant, child and youth in every old man and woman is the only way to come into the healing conditions of the geriatrist. Any other consultation is a collision, a heartless, thoughtless blur and noise which we are properly guilty and ashamed of. May we differentiate ripe and rotten. The aging process is always a ripening one, a securing of further self-experience. It is as though nature says to us aging ones, "Where I take away extravagance I add economy. Where I take away the distraction of earlier living I add the concentration of later living. Where I take away what is precious I leave what is all the more precious." There is an instructive story told of one of our early American Indians, Redjacket, who had weathered the storms of vigorous life, listening to the young Indian braves boast of their exploits. At this time he was some sixty years of age. He listened a little while, and then said, "Yes, but remember the sixties have all the forties and twenties in them." Muscles and glands are hardly recognizable for their mental significance in youth when "doing" seems hardly recognizable as a form of thinking and feeling. The great, in fact only, affairs of man are mental. Man can enjoy the full exercise of his mind as long as he lives. The active pursuit of human interests carries on as long as life does. As Solon we grow old "daily learning something new."†

The only safe and sane definition of the aging process relates it to progressingly greater self-experience. A so-called old man, realistically conceived, is one who has lived his babyhood, childhood, adolescence, and young manhood over a longer period than has someone who cannot claim his years. As Isaiah said, "For as a lad shall one die 100 years old."

Not only is *now* the prime of life, also it is the *only* time of life for everyone and the only experience anyone can ever have in eternity. All of us shall have to remain abnormally tense to the extent that we do not cultivate the present tense. Quite as Emerson perceived, "We do not count a man's years, until he has nothing else to count." There is no such possibility as just putting an old mind on old shoulders. If by the idea "growing old" the essential meaning is invested in the first word and not in the second, then our definition of

**"Young people take inordinate interest in what they think is practical study, failing to realize that self-knowledge, which is indispensable to the most practical judgments, is the highest practicality. In a period of technological prodigies and of economic complexity, the crucial problem of education is to sustain and develop the individual." 1948 Report of the Commission on Liberal Education of the Association of American Colleges.

†Note the venerable Michelangelo's motto, *Ancora imparo* (I am still learning).

aging is not a deception and we observe it truly as the accumulating of wisdom. Whoever is interested is not at all "old," or better said, whoever is interested is old in the healthy sense of the term. Dr. Holmes had the matter upright when he said, "Old babies that we are."

A third illusion holds that it is possible for us to do the respecting of old people for them. Self-respect has to be something engendered within the individual himself, and our task as physicians and educators is to provide environmental and circumstantial settings which will enable our older people not only to retain what self-esteem they have, but enable them to increase it. Self-respect is first of all the product of healthy family living. The family physician prescribes it as nourishment and remedy; the pediatrician likewise. The most efficacious geriatrics begins with the best pediatrics. Although no one can redeem an oldster's self-respect but himself, nevertheless we can do much to enable aged man to help himself in various ways involving creature comfort. It is a hopeless prospect for him to have to look forward to a future of great inequalities and we can do much to reduce such injustice. Our patients need all of the hope we can muster.‡ Pindar called hope the kind nurse of age and the companion of life, "hope which is mightiest to sway the restless soul of man."

A fourth illusion declares that it is possible to live well in a family living situation where the parents of the children are concluding, "We are going to take care of our children but we are not going to have the same respect for the individuality of their grandfather and grandmother." A person is a human being as long as he lives. *It is impossible to be humane with children without being humane with any old people who are in the home and community.* Old people react to mistreatment with mischievous behavior just as the child does. Also they react to respectful, loving consideration just as the child does. We cannot well single out anyone to be partial to at the expense of his fellowman. Our human constitution makes that impossible. Although it might appear otherwise, one man's loss cannot mean another's gain, and one man's gain cannot mean another's loss. All is going on inside of each of us, and a harm or hindrance to one part of our human nature cannot be a help to any other part. The most important dictum that was ever laid down for the medical profession is "Physician heal thyself," because that is what each one of us is doing all the time. And yet one of the most common mistakes that we encounter is this illusion that what goes on between the parents and their parents can be isolated from what goes on between the parents and the child.

A fifth illusion claims that old people are not "treatable," do not respond well to the healing agent, whereas in reality their recuperative force is wonderful. Recovery from illness is not correlated with the chronological age of the patient, but rather with the duration of the disease and the disordered personal integration which the disease is a symptom of. We have never seen a patient about whom it could be said accurately, "This patient cannot help himself, this patient cannot improve, under any circumstances." Anyone under the care of a physician forced to prescribe this unhealthy concentration of hopelessness, an outlook without insight which is too hard on the physician and too hard on the patient, ought to be referred so that both individuals will not continue hurting themselves. "Geriatrics today is a deviation from the attitude of the medical profession toward the aged and their debilities hitherto and largely even now prevailing. The medical profession hitherto has been following rather closely the general attitude of the lay public, and has been treating the aged sick with a feeling of helplessness and with apologies for Father Time. The ailments of the aged have been taken for granted, and the outcome as a foregone conclusion. However, because of a chain of circumstances—some as a result of the successful labors of the medical profession, and some for which we can take no credit —life expectancy has been steadily on the upswing."*

A sixth illusion tells us that it is easy to size up an oldster. We do not always like to identify with older people. That is the way it has to be until we learn our wonderful stake in greater sharing.

‡In his poem "The World-Soul" Emerson reminds us how hope and health spring eternal in the human breast:

"Spring still makes spring in the mind,
When sixty years are told;
Love wakes anew this throbbing heart,
And we are never old.
Over the winter glaciers,
I see the summer glow,
And, through the wild-piled snowdrift,
The warm rosebuds below."

*Excerpt from Dr. Herman Seidel's sensible report "Geriatrics and the General Practitioner." *Geriatrics,* Vol. 3, No. 2, March-April, 1948.

The same general kind of resistance tends to obstruct our awareness of our identification with our senescent and psychopathic fellowmen, namely, the fear of our unpreparedness to be kind in terms of these elements in ourselves. Napoleon helped himself greatly with a favorite maxim familiar to us practitioners: "Respect the burden." The ostracized oldster feels most keenly of all the lack of medicinal influence of his active imagination, a deficiency produced by his isolation.

When we look back through our history we find that it was always the older people who held the important places in the councils and government. For instance, senior and senate, have the same word root as senescence. The patrician of Rome has the same root as the *pater* or father. The gerusia was the Senate of Sparta. In the church we have the presbytery, the elders. Our American Indians called their Almighty, "Grandfather." All of this historical evidence refers to the health source in seeing our older self as a veteran, even as the Chinese view their elders.

Jack London with his extraordinary insight into human affairs wrote a short story entitled "The Law of Life" which depicted the method of the Eskimo for disposing of the aged, a plan involving essentially leaving the member of the family who is too old to travel with a supply of wood the sparks from which will synchronize with the spark of life. Mr. London has the abandoned old Eskimo Koskoosh living in the past, hoping his son's heart will soften so that he will return to take him on with the others less used, and reflecting upon his granddaughter Sit-cum-ta-ha's flighty mind and careless heart in accounting to himself for the fact that she did not gather more faggots. If the granddaughter were able to identify herself more accurately with her grandfather all of us are certain that the consequent woodpile would hold out until the return of the tribe.

What we are up against as one of our most difficult medical assignments is the practice of respecting our several selves in the presence of an older person. I dropped into a home room where a dear old lady was sitting up, alert, kindly, imaginative, experienced. She was eighty-eight, wearing glasses, reading books. Some of her manifestations of power had changed, taken different directions, but she was interested, she could love. In touch with all about her, she talked mostly about early Detroit. We observed at the end of the session that I had helped myself very much, particularly by finding the wonderful worthwhileness possible as long as we live. The practice of medicine *is* the practice of "Physician heal thyself," and if we physicians are not helped at the end of a session with our patients, it is a good plan to ask why we are not helped.

Sometimes it is difficult to be aware of our identification with an older person who has had limited opportunities, whose chances for respecting himself have been slim, and whose concentrated attitude is a pointed one of self-disesteem. An old lady once upset a hospital staff by repeating, "I want to die, I want to die." Finally a veteran consultant observed with her, "I can understand that you want to die, I have that feeling come to me too." She replied, "For goodness sakes, if these are normal thoughts and feelings, tell these doctors and nurses, will you, because they are making me out a monstrosity." For the first time she smiled, seemed relaxed and secure in her wisdom. It is not always easy for us to be aware of our identification with these older people because they really put our endurance to the test. They have been through so much more than we have.

If we go into a home and see the wife caring for the husband's mother, who never wanted him to marry the woman in the first place and who is still bent on bringing about a separation if possible, and the young wife "lets fly" at the mother-in-law, it helps to see that the young woman is necessarily beside herself. All she needs is to be able to help herself some more. She is in a difficult situation only made worse by the blind illusion, "You should not be the way you are." On the other hand, we have the mother-in-law who also needs to be in surroundings that would be conducive to her carefully nurturing her own feelings of self-respect. Jealousy and spite may be her ways of expressing her injured love, her ways of caring for her outraged feelings. From consulting all of the facts we soon come to the observation that every one is doing the best possible under the existing circumstances, and that all need help in order to be able to help themselves to their better best. Each of us is in Montaigne's life situation but we do not all have his 360 degree angle of self-observation, "All my hope for all my help is myself."

A seventh illusion, and in many respects the hardest to dispel of all, sees the aged man and

woman as unemployable.** Employment of the aged is desirable to the extent that it represents enjoyment. The joy of living one's own life is the unit of measure of human health. Every man's education rightly viewed has no other function than to guide him to high self-esteem. There is no better, in fact no other, way for man to live up to his capacity. All of our maturing life experiences have been amplifications of this thought, once it was found in ourselves. Blind self-disesteem forces maldevelopment and ill repute.†

Despite the constant evidence of our senses that the person who is able to see himself in the most of us is ever the most charitable of all, and that the person who can see himself in the fewest of us is ever the least charitable of all, nevertheless the fashionable objection to honest devotion to self-growth continues to be that it is too "selfish," that it is too disregardful of the rights of all. This understandable and well-meant objection to devotion to self-fulfillment is found to be a function of lack of mental integration in the objector and varies in direct proportion to the amount of mental integration present.

To be alive is to be experiencing self. That is all. According to this way of observing, it has been granted only a few people to live fully. All of us can live more fully, but only if we can learn to share more. We can share more only by acknowledging more necessities in our ever growing self. To live fully is to support "the weight of centuries," but good-naturedly instead of only mean spiritedly, "to take arms against a sea of troubles," but well disposedly, instead of only "sicklied o'er with the pale cast of thought." To live fully is to have learned from experience that mankind's instinctive repudiation of truth and necessity is sufficient explanation of all human guilt. To live fully is to have learned from experience that truth, necessity, rewards no attempts at expiation, except compliance, obedience. Only that man can be truly virtuous who has learned from experience to make a virtue of necessity. "God's will be done," says the church, of everything that is, as the indispensable beginning for subsequent changes for the better. What is the alternative to "making the best of it?"

Surely industry has the cart before the horse which allows for the product but not for the man. Let us trust that arbitrariness towards retirement age will soon be recognized as incompatible with the rights and privileges of citizenship. Emerson points up the clear truth that there is a proportion between the designs, plans, of a person's life and its duration! If we make our law a curse, by our own law we shall surely die. Until we succeed in creating a system, not of old age retirement, but of old age employment and enjoyment, which reflects reverence for the dignity of the individual man, we cannot regard our culture as essentially different from the kind which retired Koskoosh.

An eighth illusion, more disastrous than any other, puts down as peculiar to old age certain illnesses and weaknesses which have nothing to do with old age at all but rather are true both of ill health at any period and character deviations which have been carried on from infanthood and childhood. As Eli Metchnikoff put it, such "old age is a preventable disease." It is preventable, however, only if the human being living to senescence is "laying by" what he and she shall want and need most, namely, manliness and womanliness. In fact there are no illnesses or character disorders of senescence itself, as there are no such accumulations from a well-spent life. If we grow falsely old in the only way possible, by denying responsibility for our accumulating self-experiences, we suffer a form of habit deterioration, but let us not call that "old age." We have been learning to renounce the chronological prefixes to our disease entities, such as "senile" psychosis, "senile" dementia, et cetera. Da Vinci counseled, "In youth acquire that which may requite you for the deprivations of old age; and if you are mindful that old age has wisdom for its food, you will so exert yourself in youth, that your old age will not lack sustenance."

In his essay "On Old Age," Cicero has Cato reply to Scipio's admiration for Cato's carrying his advanced years as no burden, "Your admiration is easily excited, it seems, my dear Scipio and Laelius. Men, of course, who have no resources in themselves for securing a good and happy life, find every age burdensome. But those who look for all happiness from within can never think anything bad which nature makes inevitable." And later on, "Again, all things that accord with na-

**The old are not alone in this inequality. We consider youngsters old enough to die for their country whom we consider too young to vote.

†It is healthy to learn to differentiate between two ways of speaking of "self:" one, imposture, referring to a *part* of man's interests "taking him over," as when he is popularly described as "selfish;" the other, genuine, referring to the entire person, as when his individuality is observed to comprehend all of his human being.

ture are to be accounted good. But what can be more in accordance with nature than for old men to die? Accordingly, the death of young men seems to me like putting out a great fire with a deluge of water; but old men die like a fire going out because it has burnt down of its own nature without artificial means. Again, just as apples when unripe are torn from trees, but when ripe and mellow drop down, so it is violence that takes life from young men, ripeness from old. This ripeness is so delightful to me, that, as I approach nearer to death, I seem as it were to be sighting land, and to be coming to port at last after a long voyage."

If the individual has some good fortune in cultivating awareness of his self-development, there is a stabilizing and strengthening effect that comes on "with the years." All of this beneficial effect of one's personality development depends certainly on this one specific direction in which he is growing. Hence it is that we have as many different descriptions of the nature of old age as we have individuals varying in their developed self-insight.

Freedom's road is the way to an enjoyable old age. We strike the chains from the years ahead when we heed the thought of our great emancipator, "I desire so to conduct the affairs of this administration that if at the end, when I come to lay down the reins of power, I have lost every other friend on earth, I shall at least have one friend left, and that friend shall be down inside of me."‡

It is our task as physicians to represent these ideas within ourselves, to see all of our life within ourselves. To the extent that we thus "see straight," we avoid misconduct of our organs, such as high blood pressure, cancer, "coronary," as well as so-called "accidents." Illness is the surest predictable outcome of *not seeing* all of living within ourselves, of betraying ourselves, claiming that our own life is outside somewhere, has nothing to do with us. Thus we dispossess ourselves, creating within ourselves wild mental areas.*

How to live the profession of a physician in such a way that, despite the fact we are suffering from the buffetings which come from placing ourselves around the circumstances of illness, we can uphold our ideas of self-help, self-betterment—that is our "big idea." How can we begin with infants and children and live with them as individuals so that they will be self-respecting also when they are older? We are born and remain individuals, each one separate, and each one a unit, and if that fact of our individuality can be prized for the great overall truth that it is, then our mental health, strength and development are assured. There is only one way in which full self-respect can be cultivated, in our experience, and that is by way of reverence for the dignity of *all* of one's own individuality. Insight, seeing within, is our only kind of clairvoyance, and it improves with age.

Blinding illusion number nine supports the practice of the self-deception that "Time, the grim reaper" deprives us of the possession of our most

‡Abraham Lincoln, "Reply to Missouri-Committee of Seventy," 1864.

*The writer is conducting medical research at a small hospital called McGregor Center, A Hospital for Rehabilitation and Health Education. The patients are of the general practice kind. We operate as a training center for our Wayne University medical students, and also intend using our facility in training of nurses. Our orientation at McGregor Center is a simple one, common to all physicians, of being devoted to the betterment of our own health so that, in our therapeutic efforts, we can avoid that awful situation many of us parents fall into with our children, "Don't do what I do, but do as I say!" In no degree do we wish to depreciate the best one can do, however. If criticism seems to get into our orientation it is not through any conscious intention. Accusation is always a case of the pot calling the kettle black—always. We try to beware the danger of "name calling" which lurks in our need for diagnoses in all instances, including our need to see ourselves as old, selfish and alone. Our old medical "doctrine of signatures" is best renounced. This medieval doctrine of the health and disease significance of names does appear to hold some application to one's own name, as if each of us tends unconsciously to live up to what he has observed his name to stand for.

At McGregor Center our prescription is easily put down, but there is nothing else easy about it. Not in any sense is it an arcanum: *To ignore selfness is to neglect health.* This healthy self-orientation is not just an abstract philosophy but rather a concrete *feel*osophy, based upon the observation of immediate self-experience. The blind illusion of "otherness" is the essence of the force of illness, the stagnation of the imagination, the obstruction of vitality. It develops the illusion of being a "nobody," rather than the truth of being a "somebody," of amounting to all one really amounts to. In an environment of people sick from restricting their imagination, the patient's perceptions exercise his faculty of neglecting his health. Conversely, hospital personnel who are "looking out for themselves," who have made this discovery of "What is good for themselves," furnish a strengthening curative kind of environment. Awareness of one's healing meanings of well being, works the only miracle in the way of cure. The duties of our hospital personnel are to provide the wherewithal for this "miracle" by strictest devotion to the best interests of our several selves. We aim systematically to treat our patient as our self, thus methodically creating a reciprocity, a health medium in which our patient must treat his physician as his self. A true distinction between physician and patient would be that the physician has both the stronger intention and the greater means to improve his own health. A patient may be described as a man who has not yet discovered his best health interests.

cherished relatives and friends.** We can lose *our* loved ones solely by our death, but not by theirs. In our advanced years we may often hear ourselves expressing the blind illusion that we are losing more and more of our dear ones. In truth the beloved may end his life for himself alone, but not for us. All of his meaning for us continues alive as long as we do. We must suffer the blind illusion of losing our departed friend if we enjoyed only the blind illusion of gaining him in the sense of captivation in the first place. Every one of us has but one way to prevent his being deserted, and that way is not to abandon his self. We physicians have many experiences with our patients who must accomplish extra mourning work because they never had succeeded in discovering their departed's full meaning within themselves. Our capacity to love, if used well, leads to our awareness of increased self-possession, otherwise it demoralizes us. Such insight helps us to observe the deep sense in St. John's report of the wholesome parting of Jesus from the last supper where he indicated that, unless he went away, the spirit of the truth, the comforter, would not come to those remaining. We must, if we will grow well, labor with studied ingenuity to ascribe to our own human being all that we be*hold*. In no other way can our developing self, i.e., our soul, be discoverable and pathological separation reactions of desertion be prevented. Otherwise "departing" truly entails a grief whose balsam never grew.

We can but gain increasing self-possession the longer we live, not lose it, although our awareness of our adding to our human greatness rarely corresponds with its extent. Our consciousness of the extent of our increasing self-domain, the apocalypse of man, is a function of our continuing mental integration. It depends upon the stage to which we have developed in observing the center and circumference of our gravity and levity within the confines of our own individual selves, within that holy land of our own imagination. Each one of us can recognize his ever-present self-possession provided that he can keep his wits *about him*. Free men are free also insofar as they enter into circumstances around which enslaved men can liberate more of their own greatness.

**All of these illusions may be described as "blinding" to indicate that they constitute natural healthy mental material only if they can be attended by the insight that they *are* illusions.

Let us consider how our grand medical statement of self-integration is effective in our treatment of grieving over a sense of loss. Those of us suffering from our repudiated self-possessions are particularly prone to misuse our wonderful human capacity for the feeling of grief. It is quite as though we are forced to concentrate so much upon the feeling of loss that our awareness of our capacity to feel benefit is contracted to a minimum. Thus Achilles tried to help his Patroclus, "Why are you in tears, Patroclus, like a young girl?" Achilles then goes on to ask whether Patroclus is unaware that so many of his great companions are among the living, implying that if all were dead then we might greatly grieve. It does appear that Thoreau had the right of it when he observed "Nothing can rightly compel a simple and brave man to a vulgar sadness. While I enjoy the friendship of the seasons I trust that nothing can make life a burden to me. The gentle rain which waters my beans and keeps me in the house today is not drear and melancholy, but good for me too."

Grieving is a natural primitive reaction to the blind illusion of loss. To devote ourselves to it beyond this meaning is to seek vitality in a graveyard. Once we can help ourselves to see that our grief can have nothing to do with anything except our own self we have the light which reveals our being overcome by our grief as the child crying bitterly and thus giving way to hurting himself. Our general health is always abreast of our self-observation. When we use every function of our mind as a function of our mind we have the right perspective which permits our taming and training our wild feelings by observing that they are wonderful signs of *life*, not death, and are entirely contained within our several selves. Melancholia which may be accurately described as inordinate concentration upon our valuable feeling of depression is a sickening habit. The quickening hopeful attitude is the medical one. The most we can accomplish in bearing the truth of death with manly and womanly dignity is to revere our apparent losses with cheerful good sense and thus make the best of the world in which we find ourselves. Once self-observation is made the basis of our health science all becomes factual, but not before, howsoever little this idea satisfies those of us who want our thinking done for us. We find health in Homer's observation "They heal their griefs, for curable are the hearts of the noble."

Our students frequently ask how we might help the child to understand the meaning of death. Are they not asking us how to support dismal views with veneration? Are they not saying to us that they find their own thoughts and feelings about death to represent a perilous topic and that they, therefore, recognize their need to integrate the meaning of death in their own mind? Few of us care to realize that our apparent "bone and sinew," much less our present mental materials, are reproductions of earlier ones long since replaced.

For most of us the lack of human kindness to kindle kindred affection of our conception of death seems to be traceable to two primitive needs, (1) to make something out of nothing, and (2) to make nothing out of something. The one of us who can live himself most fully can trust himself most safely with ideas and feelings related to death. Why most of us are so greatly frightened at the idea of death is that it reminds us of the way in which we are living, not of death at all. Our one human error, our one demoralization to which all others are reducible, is blindly to claim for ourselves better mental health than we have. When we learn to ask ourselves freely, "What is the matter with me?" it does necessitate our renouncing our diagnosis of being in blooming health. The prominence of the feeling of immortality in youth has been remarked by William Hazlett as a procrastination of considering "the final payment of our great debt to Nature." But surely that debt is the greater the longer we live, and hence it is readily understandable, at least in part, that we oldsters are more apt to heed our greater obligation.

Growing old is most accurately defined as a continual coming to life. G. K. Chesterton writing on the pleasures of aging noted that one must live long in order to be able to see that the old proverbs are living truths instead of dead records. He observes also that the younger generation must always lack the sense of proportion upon the latest word which the perspective of former times can give only to the older generation.

Our community would show only a prudential kind of foresight if it were to develop a program heedful of the new developments in public health secondary to increased longevity in our country. Every community needs senescent guidance centers just as it needs child guidance centers. Also, clubs for old people have proven extremely practical.† They are now operating with success in Philadelphia where there are 172,000 persons over sixty-five years old. Especially in heavily populated areas our state and county medical societies have been setting up geriatric committees which are most co-operative in integrating wholesome hospital, home and wider community efforts.

Two health safeguards for human beings are a busy life and a home to live in. To guarantee health, every age of man requires fit work and surroundings. Long renewed opportunity for living is necessary to enable the insight that each one of us can take upon himself only a human part of his otherwise overwhelming world; that each of us consciously or unconsciously retires from all around him except the bit he can stand. In this seldom considered respect each one of us lives the monasterial life but only the oldster ever comes to view his lifelong voluntary and involuntary confinement clearly. In every metropolitan area there is an increasing need for healthy happy homes for elderly people requiring suitable place to live and carry on their activities self-respectfully, without having to resort to a hospital kind of living.‡

To summarize and conclude this health prescription of steady devotion to the newness, nowness and oneness of all life, the progressive health history of man can be traced by his successive stages in acknowledging his self-development, his highest health generalization being, "I am my own everything and everybody, and my neighborhood is the better because of my self insight." Thus we emancipate ourselves from the blind illusion of

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†Three such "Golden Age" clubs are now operating in our community of Highland Park, Michigan, as a part of our adult education effort. Our teachers help our older people to the club center for work and play and see them home at the end of the session.

‡A beginning might be made in organizing this kind of project by finding five or six adequately gifted women with whom the general idea of a progressive kind of home living for older people strikes fire. These several carefully screened workers could then be exposed to an expert in home planning whereby their inspirations might be implemented with related home building instructions. At the same time it would be well to have the same home makers working with a group leader whose function it would be to represent human development and integrity as it applies specifically to those of us who have plied our youth the longer time. After these home centers are established it is most important that active in-service training of the home builder's appreciation of the wonderfulness of *human being* constitute a requirement of his continuing service. Please see the helpful study "Health Requirements of the Aging Population," Warren B. Cooksey, M.D., J.M.S.M.S., 51:560 (May) 1952.

Spontaneous Rupture of the Inferior Epigastric Artery

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RUPTURE of the inferior epigastric artery with spontaneous hemorrhage into the rectus abdominis muscle or between the muscle and peritoneum is rare. Strenger, in his paper, gives three cases and states that Cullen saw only five cases in all of his thirty years of practice. In a review of the literature in the last twenty years, less than fifteen actual cases of rupture of the inferior epigastric artery have been reported.

Anatomy

The inferior epigastric artery arises from the medial side of the external iliac, about one-fourth inch above the inguinal ligament. For a short distance it passes medially between the inguinal ligament and the lower border of the deep inguinal ring, lying in the extraperitoneal fatty tissue. It then changes its course and passes upwards and medially lying close to the medial side of the deep inguinal ring. On arriving at the lateral border of the rectus abdominis, at a point about midway between the upper border of the symphysis pubis and the umbilicus, it pierces the fascia transversalis and ascends within the sheath over the arcuate line. It then changes its course and ascends vertically between the muscle and the posterior wall of the sheath as high as the umbilicus. Here it enters the muscle and about two inches above the umbilicus ends in its terminal branches which anastomose with branches of the superior epigastric artery. The inferior epigastric lies at first in the preperitoneal areolar tissue, having the parietal peritoneum on its deep surface and the fascia transversalis superficial to it. Shortly after passing the deep inguinal ring the vessel pierces the fascia transversalis and in its course to the lateral border of the rectus forms the outer boundary to the inguinal (Hesselbach's) triangle. As the vessel turns from the lower border to the medial side of the deep inguinal ring it has the spermatic cord in front of it and the vas deferens hooks round its lateral side. The course of the vessel in its first or oblique part is indicated by a line from the medial border of the deep inguinal ring to the lateral border of the rectus abdominis at a point about midway between the umbilicus and the superior border of the symphysis pubis. The course of the second or vertical part of the vessel is represented by a line corresponding with the center of the rectus and about one and one-half inches from the linea alba.

Etiology

The immediate cause of a rupture may be slight exertion such as coughing, straining, moving about, but very seldom trauma. At times there may be degeneration of the vessels themselves with subsequent rupture. Rupture of the inferior epigastric vessels may be seen in pregnancy. However, in most cases one fails to elicit any history of a foregoing cause.

Diagnosis

Usually the earlist and most constant symptom is pain. Pain is usually located in the area of the ruptured vessel. The degree of pain is in proportion for the most part to the size of the resulting hematoma caused by the rupture. Ecchymosis of the skin is present, but a duration of three days will ensue before its appearance. A mass in the area of the rupture is usually found. Tenderness is present in most cases. The hematoma may be large enough to protrude into the peritoneum downward to imitate a pelvic tumor. This occurred in one of our cases.

Treatment is usually excavation of the hematoma, control of bleeding points, obliteration of dead space and means to combat infection secondary to injury.

Case Report

Case 1.—The first case to be presented is one of Mrs. J. F. This patient entered the hospital on September 17, 1951, on the surgical service. The patient gave a history at that time of an acute upper respiratory infection with a severe cough developing approximately two weeks prior to admission, and following a severe coughing episode the patient noticed pain in the left lower quadrant of her abdomen and also a discoloration of skin around an old previous midline incisional scar. Patient stated that she had lost six pounds in the past two weeks and that she had some frequency of urination during the past several days. She had no other particular symptoms referable to her present illness.

The past history by systems was essentially negative. She had had no previous symptoms or signs that may be

attributed to the urinary tract. The patient stated that her last menstrual period was in 1944, practically seven years before her entrance. She was a Para II, Gravida II.

Her surgical history consisted of a hysterectomy and appendectomy.

The medical history was essentially negative.

The family history was non-contributory.

The physical examination revealed a well-developed, well-nourished, slightly obese, white, fifty-five-year-old woman in no acute distress. Blood pressure was 118/110 mm. Hg; temperature 98.6; and respirations 18. Examination of the head and neck were within normal limits, as was the examination of the chest. The main physical findings in this examination were found on the abdomen. For two or three centimeters on either side of an old midline scar in the lower half of the abdomen there was evidence of subcutaneous hemorrhage with discoloration of the skin. The skin around the incision was blue to purplish in color. There was a hard, firm immovable mass which was irregular in outline and approximately the size of a large orange palpable in the left lower quadrant of the abdomen. There was only slight tenderness to palpation in that region. The rectal examination was within normal limits. The pelvic examination revealed external genitalia normal, vaginal mucous membrane atrophic, the floor was relaxed, the cervix was clear, the corpus was absent. There was a hard, fixed, round, non-tender mass high in the pelvis or the left lower quadrant of the abdomen. Extremities were normal. No adenopathy was palpable and the reflexes were physiological. The impression of the attending surgeon at this time was a left ovarian tumor.

The laboratory report showed a leukocytosis of 12,500. The differential was within normal limits. The red blood cells and hemoglobin were within normal limits. The Kahn was negative. The urinalysis was within normal limits. A barium enema was negative for demonstrable colon pathology.

The patient was taken to surgery with the diagnosis of a left ovarian tumor. Under sodium pentothal, nitrous oxygen and ether anesthesia, a midline incision was made through the previous incisional scar in the lower midline in the anterior abdominal wall. The incision was extended down to the peritoneum, the peritoneum was grasped with mosquito forceps and opened by sharp dissection. Manual and visual exploration of the pelvis revealed normal ovaries, normal adnexa. The uterus was absent due to a previous hysterectomy. The peritoneal-anterior wall on the left side was noted to be bulging into the pelvic cavity. Exploration laterally to the left in the anterior abdominal wall revealed a large hematoma between the posterior surface of the rectus muscles and the posterior rectus sheath and the transversalis fascia and the peritoneum. This hematoma was approximately six or seven centimeters in diameter. An incision was then made through the anterior rectus fascia and approximately 75 cc. of dark red blood and dark red blood clots were expressed through this incision. A smaller incision was made in the rectus sheath over the left rectus muscle and a drain inserted. Before this was done, the area of the inferior epigastric artery was ligated. The anterior abdominal wall was then closed in a routine manner. The postoperative diagnosis was a rupture of the inferior epigastric artery with a resulting hematoma into the anterior lower abdominal wall.

Following this procedure the patient made an uneventful recovery and was discharged on the seventh postoperative day.

Case 2.—The second case presented was Mrs. A. B., who entered the surgical service of this hospital on January 19, 1952. She gave a history of pain in the lower left quadrant for the past three months with an associated enlargement of the abdominal girth. Menses had ceased two years previous to entry. She has experienced no weight loss, no urinary symptoms. She stated that the only thing that she had noticed was that her girth had enlarged around this mass in her left lower quadrant along with pain.

The past history revealed that she had had no previous surgery.

Her medical history revealed that in 1940 she had an onset of low back pain radiating up into her hips, and the pain had progressively radiated down past the aspect of leg to ankle. This had been diagnosed as arthritis.

Family history was essentially negative.

Physical examination revealed a well-developed, well-nourished, white woman in no apparent distress. Blood pressure was 120/80 mm. Hg; temperature, 98.7° F., and respirations, 16. Skin, head and ears, nose and throat were within normal limits. The adnexa was within normal limits. Chest, heart and lungs were all within normal limits. The breasts were negative. In the lower left quadrant of the abdomen there was a mass extending to the midline up through the umbilicus, markedly tender. The back revealed tenderness over the fifth lumbar. The extremities were within normal limits. There was no adenopathy and the reflexes were within normal limits. The pelvic examination at that time revealed a mass palpable in the lower left quadrant with tenderness present, which was impossible to outline directly. The perineum revealed a slight cystocele and rectocele. The uterus was in an anterior position, movable but not without pain when palpated. The left adnexa was distended by a large cystic mass approximately 10 cm. in diameter. The cervix was slightly eroded. The impresison at that time was an abdominal mass probably left adnexal in origin.

The laboratory work of this patient was all within normal limits. A barium enema was done and it was concluded that the colon was negative for demonstrable pathology but an extra-alimentary tumor was present in the left lower quadrant.

With a preoperative diagnosis of ovarian cyst or hematoma of the abdominal wall, the abdomen was opened. This being the second case with a similar type of findings, hemorrhage from the inferior epigastric artery was suspected.

Under sodium pentothal and nitrous oxide anesthesia, the patient was prepared and draped in the usual man-

ner. The abdomen was opened through a lower abdominal midline incision with the right rectus compartment being entered. The extraneous tissues were excised. There was a purplish discoloration of them indicating that there was a hemorrhage of the abdominal wall. The right rectus compartment was inspected, but evidence of further hemorrhage was not here. The left rectus compartment was then entered and a rent in the left rectus muscle extending practically two-thirds through its entirety, was discovered. The peritoneal cavity was opened through the right rectus compartment. The appendix was then isolated and removed. Definite bleeding points could be isolated in the left rectus muscle and the posterior rectus sheath. These were ligated. An oxycel pack was then inserted and after the bleeding seemed to be fairly well controlled a rubber drain was also inserted in the region of the oxycel. The rectus muscle was then sutured down to the midline at either side, the fascia was closed with continuous sutures of chromic No. 2-0 and the subcutaneous sutures were plain No. 0 catgut. The skin was closed with interrupted mattress sutures, a dressing was applied. The patient withstood the procedure well and left the operating room in good condition. Here again, the source of the hemorrhage was the inferior epigastric artery.

The postoperative course was uneventful and the patient left the hospital on the eighth postoperative day.

Conclusion

1. Spontaneous rupture of the inferior epigastric artery without trauma occurs.

2. Etiological factor in both cases was a respiratory infection with cough.

3. The subcutaneous ecchymosis is a late sign because of the muscle and fascia through which the blood must penetrate before becoming subcutaneous.

4. Pain, subcutaneous tumor-like pelvic mass and ecchymosis, are the cardinal symptoms.

5. The surgical therapy is discussed.

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3925 Joy Road

ARTHRITIS AND GERIATRICS

(Continued from Page 508)

Conclusions

The great majority of elderly patients have poor posture which often is the cause of or accentuates rheumatic disabilities. Regular exercises is advised to keep joints functioning properly and also to stimulate peripheral circulation. Osteoarthritis is common in elderly people and responds fairly well to physical therapy, preferably a Hubbard tank, and occasionally the use of corrective orthopedic surgery to the hips or knees is of great value. Be suspicious of any acutely painful and swollen joint —in men or women—it may be gout!

Bursitis is increasing in frequency; treatment of bursitis of the shoulder involves the use of deep x-ray therapy, physical therapy, or orthopedic surgery. ACTH or Cortisone should be used with great discretion in the elderly patient. A warm, dry climate is of great benefit to all older individuals with musculoskeletal disabilities. Correction of anemias and vitamin deficiencies are an essential adjunct to therapy.

UPON CONSIDERING MY AGE

(Continued from Page 531)

unself which killeth and become physician of the self which maketh alive. Your scribe, whose age at least entitles him to have considerable authority, may agree with Cicero that the composition of this work "has been so delightful, that it has not only wiped away all the disagreeables of old age, but has even made it luxurious and delightful, too."

1512 St. Antoine Street

St. Luke's Hospital Clinico-Pathologic Conference

Edited by J. C. Smith, M.D.
Saginaw, Michigan

THE PATIENT was a white woman, twenty-seven years old, who was well until two months before hospital admission. At that time, she developed pain in the right infrascapular region that radiated to the right shoulder. This pain was accentuated by coughing and by deep inspiration. Three days later, she also developed epigastric pain that was associated with slight nausea. Radiographic examination of the chest was normal. Further studies revealed a small gall bladder in which concretions were not seen. Function was stated to be normal although it was noted that only a small amount of dye entered the gall bladder. Radiographic examination of the gastro-intestinal tract, done elsewhere, was interpreted as showing an ulcer of the duodenum. The patient was given a Sippy diet and there was some improvement.

About three weeks later, pain developed in the lower abdomen and in the right upper quadrant. The pain was constant and steadily increased in severity. This was associated with nausea, vomiting, and slowly progressive distention of the abdomen. Slight jaundice was first noted at this time and the discoloration became progressively more pronounced. One month after onset of the abdominal pain, a pelvic tumor was discovered and the patient was admitted to the hospital. During the past two months, there had been progressive weakness and weight loss of about 30 pounds.

Review of systems elicited no other complaints.

The past history disclosed that the patient had completed a normal pregnancy with birth of a baby boy, by uncomplicated labor, five weeks before the onset of the present illness. It was also learned that a radical mastectomy had been performed for carcinoma of the right breast four years before the present illness. The tumor measured 2.5 cm. in greatest diameter, and was in the central portion of the breast. No metastases were found in several lymph nodes. After this operation, the patient was given twenty x-ray treatments and physical examination, every six months during the past four years had revealed no recurrence.

Physical examination revealed an acutely ill, semicomatose white woman complaining of severe pain in the abdomen. The temperature was 99.0 degrees (F.), respirations 28, pulse 110, and blood pressure 100/70 mm. Hg. The skin and sclerae were moderately icteric. The head and neck were normal. The right breast was absent and there was a large, soft scar in that region. The left breast was normal. No lymph nodes were palpated in either axilla. The lungs were clear to auscultation and percussion. The heart was not enlarged, the rhythm was regular, and no murmurs were heard. The abdomen was distended and soft. Shifting dullness and a fluid wave were elicited. The liver margin, 6 cm. below the right costal border, was smooth, firm, and nontender. There was tenderness in the epigastrium and suprapubic region. Pelvic examination revealed a firm, oval, and freely moveable mass in the region of the left ovary, that was estimated to measure about 10 cm. in diameter. The uterus was displaced to the right and was stated to be subinvoluted. There was slight pitting edema of both lower extremities. Neurologic examination was normal.

The urine was cloudy, reddish brown, acid, and of specific gravity 1.015. The urine contained bile and uric acid crystals and the sediment revealed twenty leukocytes and forty epithelial cells per high power field. Hematologic examination revealed 13.6 grams of hemoglobin per 100 cc. There were 4,200,000 erythrocytes and 9,200 leukocytes per cu. mm. Differential count of 100 cells revealed sixty-nine segmented granulocytes, twenty-eight lymphocytes, and three band cells. Bleeding and clotting times were normal. The Van den Bergh test was direct, prompt, and indirect, 46.9 mg. per 100 cc. The serum alkaline phosphatase was 9.2 Bodansky units. The prothrombin time was 75 per cent of normal. Cephalin flocculation was negative and thymol turbidity was 1 plus. Radiographic examination of the chest was normal. A flat plate of the abdomen revealed only moderate distention of the colon and slight evidence of ascites. Paracentesis yielded 675 cc. of clear, pale yellow fluid from which a portion, on microscopic examination, disclosed no tumor cells. The jaundice was progressive and the patient became rapidly worse and died on the tenth hospital day.

Discussion of Case

DR. WM. B. KERR:—In this case, we have a twenty-seven-year-old, white woman who was well until about two months before admission to the hospital. Four years previous to that time, she had had a malignancy of the right breast, removed by radical mastectomy, after which there was no clinical evidence of metastasis. In addition, an adequate course of deep x-ray therapy was given. She was then well until the present illness except for pregnancy with normal delivery five weeks before the onset of complaints. Her early complaints appear referable to the organs below the diaphragm with radiation of pain to the shoulder. Soon after this, progressive jaundice developed. The direct Van den Bergh test was prompt and the quantitative serum bilirubin was 46.9 mg. per 100 cc. Thymol turbidity and cephalin flocculation were normal. This indicated obstructive jaundice without diffuse hepatic disease. In addition, ascites developed suggesting some degree of portal obstruction. Lastly, there was subinvolution of the uterus, and a tumor, apparently of the left ovary.

With these essential findings, several diagnoses are to be considered. The uterine enlargement with rapidly progressive course occurring shortly after pregnancy, are consistent with chorioepithelioma. However, pulmonary metastases are expected and we do not have an Ascheim-Zondek test which would be most helpful. Carcinoma of the head of the pancreas often produces massive hepatic metastases with portal obstruction and short progressive course. The patient was only twenty-seven and had had one malignant tumor. To consider a second primary tumor at this age is, in my opinion, unwarranted. For the same reasons, I am reluctant to think that the

Clinical discussion by William B. Kerr, M.D.

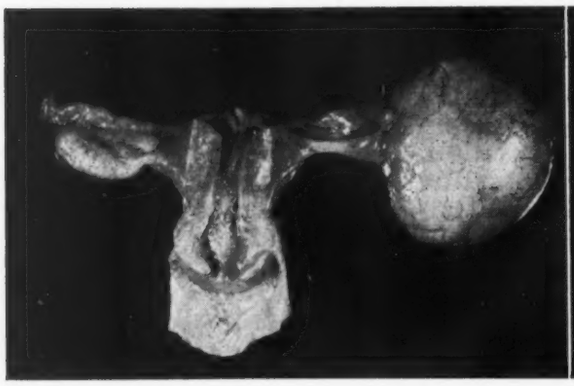

Fig. 1. Metastatic carcinoma of left ovary.

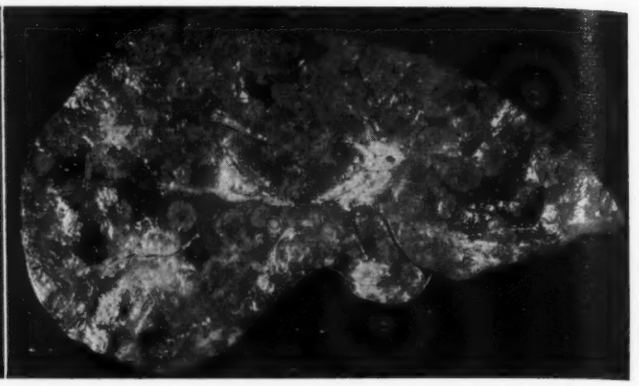

Fig. 2. Metastatic carcinoma of liver.

ovarian tumor was a second primary carcinoma. I shall exclude diffuse hepatic disease such as yellow atrophy or viral hepatitis on the basis of normal liver function tests. There is also the possibility that the ovarian mass was a Krukenberg tumor. However, the gastrointestinal tract was normal by radiographic examination except for the duodenum. Here, the clinical evidence is inconclusive and this is an unusual site for carcinoma, particularly at the age of twenty-seven years. This leaves latent metastatic carcinoma of the liver and left ovary that was activated by the hormonal changes of pregnancy. The difficulty with this diagnosis is that there are no demonstrable metastases in the lungs or in the cervical, axillary, or mediastinal lymph nodes. I would very much expect these lesions to be present. Nevertheless, this diagnosis calls into consideration only one disease, and pregnancy is known to stimulate the metastases of carcinoma of the breast. Therefore, the most likely clinical diagnosis is, in my opinion, metastatic carcinoma of the breast affecting particularly the liver and left ovary.

Visitor:—It seems to me that this patient had been cured of her breast tumor. The carcinoma was small, sections demonstrated no axillary lymph node metastases, she was given twenty x-ray treatments, she was in good health for four years, and the chest plate showed no pulmonary metastases as late as ten days before death. I believe she had a second primary carcinoma arising in the left ovary with abdominal and hepatic metastases.

Dr. H. T. Caumartin:—In most cases, a five-year survival is a reasonably good index of cure for a malignant tumor. However, in carcinoma of the breast, metastases may not appear for many years after apparent cure. I do not think that the negative chest x-ray and the four-year period of apparent good health should necessarily disfavor a diagnosis of metastatic tumor.

Dr. Kerr:—In the clinical decision here, between metastatic tumor and a second primary carcinoma arising in the ovary, it seems to me that the known adverse influence of pregnancy on breast cancer should be the deciding factor. Thus, I would exclude primary ovarian carcinoma.

Dr. Kerr's Diagnosis

Metastatic carcinoma of the breast with involvement of liver and left ovary.

Anatomic Diagnosis

(1) Metastatic undifferentiated carcinoma of left ovary, liver, gall bladder, pancreas, pancreatic lymph nodes, and upper lobe of left lung. (2) Absence of right breast. (3) Bronchopneumonia, lower lobes of right and left lungs.

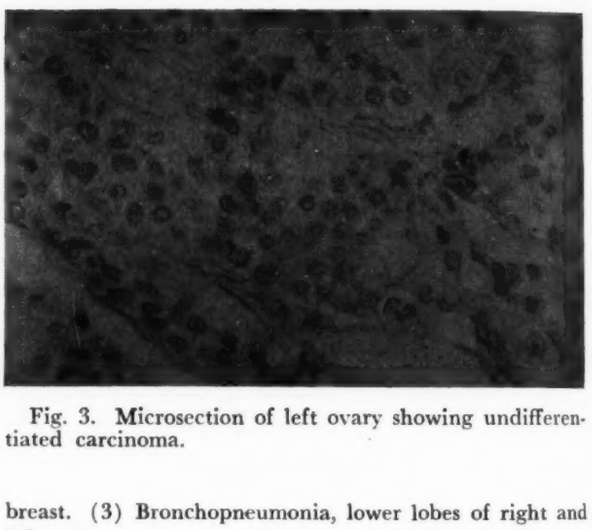

Fig. 3. Microsection of left ovary showing undifferentiated carcinoma.

Dr. J. C. Smith:—The metastatic lesion of the left ovary was represented by a large, smooth, firm and solid tumor that was freely moveable. (Fig. 1) Interest in this case centers about this type of ovarian metastasis as reports of similar cases are uncommon. The other pelvic structures were essentially normal. There was extensive involvement of the liver by metastatic tumor. (Fig. 2) In view of this, it may seem unusual that the thymol turbidity and cephalin flocculation were normal. However, it is known that slight diffuse hepatic disease is often reflected by marked reduction of liver function whereas extensive focal disease frequently leaves sufficient parenchyma to maintain normal function. The amount of parenchyma necessary for this may be surprisingly small as we see here. An ulcer of the duodenum was not found. Death is attributed to pronounced bronchopneumonia of the lower lobes of both lungs.

In 1951, Karsh[1] reported a review of 10,287 autopsies that included 158 carcinomas of the breast. In eighteen of the latter, there were ovarian metastases. Both ovaries were involved in eleven, and in nine there was enlargement. In eleven, the histologic type of secondary tumor was undifferentiated carcinoma. Other sites of primary tumor from which there were ovarian metastases included cervix, thirteen; colon, ten; stomach, eight; uterine fundus, six; and lung, two. Karsh pointed out that in this series, the ovary was involved by metastatic tumor more often from the breast than from any other single organ. He also noted that the breast so involved the ovary as frequently as all primary tumors of the

(Continued on Page 542)

Detroit Physiological Society

MEETING OF JANUARY 15, 1953

Studies on the Physical Chemistry of Bone Salt Formation

RODERICK P. MACDONALD
Wayne University College of Medicine

Inorganic precipitates and their supernatant solutions, having compositions similar to bone and serum ultrafiltrate, respectively, were prepared by equilibration of salt solutions under physiological conditions. On the basis of theoretical consideration, the following equation was derived for the expression of the relation of the composition of the precipitates to their supernatant solution.

$$\frac{[CaCO_3]_p}{[Ca_3(PO_4)_2]_p} = K\,[\log (CO_3^{=}) - 0.2 \log (Ca^{H}) - 0.8 \log (PO_4^{\equiv})]_p$$

When the conditions of equilibration were altered by varying the ratio of calcium to phosphate, the bicarbonate concentration, adding magnesium, or changing the pH of the supernatant solution, the relationship was found to hold. Commercial calcium phosphate (which also contained carbonate) was equilibrated under similar conditions for a suitable period of time, and the analytical data were substituted into the equation. A straight line relationship existed. Mixtures of commercial calcium phosphate and calcium carbonate were equilibrated and found to give similar results. Thi- calcium phosphate was prepared and equilibrated, but this salt did not adjust itself to the composition predicted by the equation. It is suggested that this may be due to a different crystal structure. When various amounts of this tricalcium phosphate were added to equilibrating mixtures which would normally form precipitates agreeing with the equation, the precipitates failed to reach the appropriate composition. The degree of deviation depended upon the quantity of tricalcium phosphate added.

Analytical data for bone and plasma were available for different age groups, and substitution of these data into the equation resulted in a straight line relationship comparable to that obtained through the *in vitro* studies.

Laboratory Observations on Parahemophilia and Proconvertin Deficient Plasmas

J. FREDERIC JOHNSON, and WALTER H. SEEGERS
Wayne University College of Medicine

For the investigation of the blood clotting mechanisms it is often of strategic advantage to utilize pathologic plasma or purified coagulation components. In this study we used both. Plasma from patients with proconvertin deficiency and also from parahemophilia (Ac-globulin deficiency) was made available to us through the courtesy of Professor Paul Owren of Oslo. Purified prothrombin was made in our laboratories by techniques previously described.

The quantitative analysis for Ac-globulin used in this laboratory requires purified prothrombin as the substrate. As indicated by Table 1, analysis showed that the Ac-globulin deficient plasma did not contain any Ac-globulin. This is in accord with the quantitative aspects of Owren's experiments and is the first direct confirmation of the generally accepted view that factor V and Ac-globulin are the same factor. By adding a concentrate of proconvertin (material of serum adsorbed on $BaCO_3$ and eluted with sodium citrate) to parahemophilia plasma there was still no Ac-globulin found upon analysis; however, a platelet extract similarly added to the plasma did show some Ac-globulin. This latter result is due to the presence of an Ac-globulin-like substance in platelets.

TABLE I. AC-GLOBULIN ANALYSES IN UNITS PER ML.

	Nothing added	$BaCO_3$ eluate added	Platelet extract added
Proconvertin deficient plasma	1-2	12	11
Ac-globulin deficient plasma	trace	trace	1-2

The quantitative Ac-globulin analysis of the proconvertin deficient plasma (Table I) indicated that it contained less than two units of Ac-globulin

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Editorial

HELP MAKE A 3,000 ATTENDANCE RECORD IN GRAND RAPIDS
MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

THE HOUSE of Delegates of the American Medical Association held one of its very rare special meetings in Washington, D. C., on March 14, 1953. President Eisenhower had announced his intention of reorganizing the executive branch by making the Federal Security Administration into a new Department of Health, Education and Welfare, with certain changes in the present structure, and a place in the Cabinet for the administrator, Mrs. Oveta Culp Hobby.

Being vitally interested, and twice having been instrumental in the defeat of a somewhat similar plan proposed by President Truman, the American Medical Association called a special session of its House of Delegates to meet in Washington to consider the proposal. The recommendation was sent to Congress on March 13, and contained a provision for an Associate Secretary of Health, through which office all medical matters of the entire Federal Security Administration and its six various major divisions were to be channeled. This, and a personal promise from President Eisenhower that during his term there would never be a suggestion in any way to socialize medicine, prompted the House to vote approval of the statement prepared by the Trustees as follows:

Report of the Board of Trustees on Reorganization Plan No. 1 of 1953 Adopted Unanimously by the House of Delegates on March 14, 1953

"The House of Delegates of the American Medical Association has for nearly eighty years been on record as favoring an independent Department of Health in the federal government. The reason for this stand has been that the House has felt that health and medicine should be given a status commensurate with their dignity and importance in the lives of the American people, and that they should be completely divorced from any political considerations.

"The Board of Trustees, after a careful study of the policy of the American Medical Association with respect to the administration of health activities in the Executive Branch of the government and after studying the Reorganization Plan for elevation of the Federal Security Agency to cabinet status submitted by President Eisenhower to the Congress, finds that Reorganization Plan No. 1 of 1953 provides for a special assistant to the Secretary for Health and Medical Affairs. This provision is a step in the right direction which should result in centralized co-ordination under a leader in the medical field of the health activities of the proposed department. Health, therefore, is given a special position. The proposed plan, properly administered, will permit more effective co-ordination and administration of the health activities of the new Department without interference or control by other branches.

"Previous attempts to raise the Federal Security Agency from an independent agency to the level of an Executive Department have been opposed by the Association because the plan did not meet these aims.

"Inasmuch as federal health benefits and programs are established by the Congress, an administration bent on achieving the nationalization of medicine cannot reach that goal except with the support of Congress. Therefore, an organizational plan through which federal health activities are administered, although important, is not nearly so vital an issue as the policies adopted by the Congress of the United States.

"The Board of Trustees recommends that the House of Delegates reaffirm its stand in favor of an independent Department of Health but that it support the Reorganization Plan No. 1 of 1953 as being a step in the right direction; that the American Medical Association co-operate in making the plan successful and that it watch its development with great care and interest.

"It should be understood, however, that the Association reserves the right to make recommendations for amendment of the then existing law or to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in and protection of health and medical science and in their freedom from political control."

For the first time in two decades, the medical profession and its official organizations have the opportunity to work with a friendly government. The representatives of the profession promised complete support, with the reservation that if the present plan does not work we shall again ask for a Department of Health, as we have for over eighty years.

Co-operation and trusting understanding may well make this arrangement an ideal one, and lead to an era of growth and effort never before experienced. We so hope and believe.

An Ounce of Prevention

Now that March is past and we have all made our report to the Bureau of Internal Revenue, and April showers and cold have given way to the balmy days of May, we may have overlooked the passing of a very important date. This, may I have the temerity to say, was the opening day of trout season! The 25th of last month may or may not have assumed importance on your individual calendar, but, if not, some date in the year should signify a turn of events that means at least a temporary putting-aside of the confining practice of medicine. Possibly trout fishing is not your means of escape, although I dare say you could do a lot worse, but some means there must be, and the closer to nature it takes you, I believe, the greater will be its reward. Perhaps the golf tee is your favorite, or possibly seeking out the wild orchid.

Albeit, my message is that the path of least resistance is to become so engrossed in the work of our profession that we are liable to overlook the stress on our own physical being and the companionable needs of our families. It has been said that the emotional stress frequently encountered by the physician in the care of his patients could be likened to that of a bank president, when a run on his bank occurs. Be that as it may, all too often one of our brother physicians is stricken with a coronary lesion, that always seems too early, and requires a reappraisal of his activity and generally a forced reduction in the stress factors in his work—Perhaps we should more often practice the dictum, "An ounce of prevention is worth a pound of cure."

President's Message

R. J. Hubbell

President, Michigan State Medical Society

"MICHIGAN FIRSTS"

FOR MANY years, the Michigan State Medical Society has been boasting to its members of certain "Michigan Firsts," and has pointed with pride to numerous economic, administrative, and organizational advance efforts in behalf of the Michigan public and our own advancement in prestige. We have also mentioned several "firsts" in the advanced medical thought, or introduction of something new in the field of medicine.

During the recent Michigan Clinical Institute, those who attended the program session on Friday morning, March 13, 1953, saw another "Michigan First," a movie demonstration, "Some Aspects of the Mechanical Heart," by Robert D. Dodrill, M.D., Detroit. A colored movie was shown of the first operation on a human patient, with the sidetracking of one side of the heart, the exposure of the tricuspid valves, their repair, and the closure. The human heart had been bypassed for twenty-five minutes to allow surgical repair. We are told the mortality to date is seven in nine. There are two recoveries.

Unfortunately, we cannot show a motion picture in THE JOURNAL, but the Editor was impressed by the presentation.

About a year ago, the Editor published a "First" in Medicine, "the first use of adrenalin in the treatment of asthma," and referred to the first report of mitotic figures in the circulating blood, with the suggestion the leukemias were a cancer of the blood, a concept which has now been accepted forty years after the first suggestion. We added that if any of our members know of such "firsts" in medicine that they write them up and submit them to us for publication.

Among the book reviews in the April JOURNAL is a tribute to two "firsts" by a Michigan doctor, John M. Sheldon of Ann Arbor, who recently published a new book entitled "A Manual of Clinical Allergy."

MEDICAMENTS OF KNOWN POTENCY

A FEW DAYS ago, one of our prominent Michigan pediatricians reported having some children referred to him with the notation that they had not responded to rather large doses of penicillin, and would the doctor make suggestions in the matter of treatment. The pediatrician thought penicillin indicated and proceeded to give the drug prepared by a well-known supplier. He was gratified to get prompt and satisfactory response.

Inquiry developed that the drug previously given had been supplied by distributors who buy in quantities and resell to the physician. Had the drug been on some shelf long enough to lose its published potency?

The responsibility of the Doctor of Medicine to his patient is to make sure his diagnosis is properly arrived at, and that the medication he supplies or advises is of standard potency. All drugs and medicaments which may deteriorate, if supplied by the well-recognized firms, have a date stamped on the package beyond which the potency is not guaranteed. If our members have in their supplies outdated serums, antibiotics, or other materials, they should turn them back to the manufacturer or jobber for replacement. Reliable firms are glad to make this replacement.

A FRIEND IN CONGRESS

ON MONDAY, March 16, immediately following the session of the House of Delegates of the American Medical Association, a hearing was held by the Subcommittee of the House of Representatives to discuss and consider the President's Plan Number 1. During the hearing at which Congressman Claire Hoffman, from the Fourth District of Michigan, was presiding, the question of the "powerful American Medical Association lobby" was mentioned, with the implication of its strength in compelling Congress to consider with favor topics in which the American Medical Association was interested. Mr. Hoffman said he had heard enough about "the huge 20 million slush fund" the American Medical Association had for lobbying. Was there anyone present who knew the facts? John Cline, M.D., past president of the American Medical Association, said he had the figures in his pocket, just received from the auditors. He gave them to the presiding officer.

The facts are that the American Medical Association maintains a Washington office as an information center, both for members of the profession and members of Congress. It was first established in 1943. At present, it has a staff of fifteen persons, three physicians, two editors, a lawyer, a business manager and his assistant, and an executive assistant. Two of these are registered as lob-

(Continued on Page 565)

Michigan's Foremost Family Physician Looks Ahead—Never Backward

Sherman L. Loupee, M.D., of Dowagiac, Michigan's Foremost Family Physician for 1952, is a true country doctor from the agricultural area of southwestern Michigan.

Sherman L. Loupee, M.D., Dowagiac, Michigan's Foremost Family Physician for 1952, accepts a resolution presented to him by State Representative John W. Fletcher, of Centreville. The resolution, passed by both the House and Senate of the 1953 Michigan Legislature, honored Dr. Loupee, a former colleague who served in the State Legislature from 1939 to 1949. Mr. Fletcher represents the counties of St. Joseph and Cass and holds the seat once occupied by Dr. Loupee.

While all his life Dr. Loupee has wanted to be a rural doctor of medicine in a rural community, his influence and judgment have gone beyond the rolling countryside where he has practiced medicine more than forty-eight years.

He is a long-time member of the Michigan State Medical Society House of Delegates. Currently, he is Mayor of Dowagiac. He was elected to that position last spring. This present community service is but one of the many political positions he has felt duty-bound to fill.

The veteran practitioner was named Michigan's Foremost Family Physician for 1952 by the Michigan State Medical Society House of Delegates at the 1952 Annual Session in Detroit last September. A scroll, presented by Reader J. Hubbell, M.D., Kalamazoo, President of the Michigan State Medical Society, was awarded Dr. Loupee on March 11, 1953, during the Michigan Clinical Institute in Detroit in recognition of his selection.

The eighty-year-old country doctor, who tells others "never look backward," can still in retrospect review a brilliant career of service to his fellow man.

For ten years, he distinguished himself and his medical profession while serving in the Michigan

THE COVER

Sherman L. Loupee, M.D., Dowagiac, Michigan's Foremost Family Physician for 1952, surrounded by a sampling of newspaper stories regarding the selection and subsequent honors.

State Legislature. In five consecutive terms from 1939 to 1949, he actively supported legislation, particularly in the fields of health and education. As a member of the House Committee on Health, he fought consistently to maintain the high standards of the medical profession.

He was also chairman of the House Committee on Education during his final term in the Legislature. Dr. Loupee's assistance on a special education committee was instrumental in developing a state aid bill which has been described as the most equitable state aid bill of all time.

The 1953 Michigan Legislators, sitting in joint session on March 2, honored their former colleague by presenting him with a resolution passed by both the House and the Senate.

Dr. Loupee was born September 4, 1872, at Union, Michigan. He attended Michigan Normal College at Ypsilanti and was graduated in 1899. While his first interest at that time was in teaching, he decided to become a doctor of medicine. He entered the College of Physicians and Surgeons at the University of Illinois and received his medical degree in 1904.

He first began the practice of medicine in Vandalia, Michigan, where he also found time to serve as village president and on the school board. In 1919 he moved to Dowagiac where he has continued to practice and still devotes a portion of his time as a member of the Dowagiac school board.

The octogenarian who never looks back has others who admire and respect him—others who remember the 4,800 babies he has delivered. They remember the advance of medicine he has seen from the horse and buggy days. They remember the calls he made into the country on horseback.

But Doctor Loupee looks ahead and sees a great future for medical science in the discoveries now being made and yet to be made.

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 537)

per ml. as compared with the normal value of 13 to 17 units. By first mixing a concentrate of proconvertin or platelet extract with the proconvertin deficient plasma it was possible to get the quantitative results for Ac-globulin content of the plasma to approach normal. Thus material adsorbed on $BaCO_3$ and eluted with sodium citrate contains very little if any Ac-globulin itself, but can enable proconvertin deficient plasma to develop its full Ac-globulin titre. Platelet extracts develop a similar titre in proconvertin deficient plasma. By contrast with these experiments our method for Ac-globulin analysis gives normal values for dicoumarol plasma without addition of platelet extract or $BaCO_3$ eluate preparation. Nevertheless dicoumarol plasma is supposed to be deficient in proconvertin.

These experiments show that our purified prothrombin preparation contains very little if any proconvertin or Ac-globulin, and point to interrelationships between Ac-globulin, platelet extracts and proconvertin not previously described. It is our view that certain current theories about the action of these three substances are not adequate. Furthermore, it is probably necessary to have these substances in purified form before their biochemical action can be described.

This investigation was supported by a research grant from the Michigan Heart Association.

ST. LUKE'S HOSPITAL CLINICO-PATHOLOGIC CONFERENCE

(Continued from Page 536)

gastro-intestinal tract combined. Remold[2] found thirty-six cases of breast carcinoma occurring during or before pregnancy, in a review of 2,455 cases of breast carcinoma treated from 1918 to 1950. He emphasized that pregnancy incites an adverse effect on carcinoma of the breast, and recommended that all cases be treated promptly, and that even after a long well period, pregnancy is not without danger. He recommended that castration by x-ray be performed in all such cases. Siegert[3] reported on 607 cases of carcinoma of the breast in which 347 were castrated by x-ray and 260 were not. There was an average delay of 1.3 years in the clinical appearance of metastases in the castrated series as compared with the non-castrated series. Siegert recommended that castration be performed in all cases of carcinoma of the breast if the patient is still in the active menstrual period.

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Childhood constipation deserves treatment which gently restores normal peristaltic movements; drastic elimination cannot permanently correct the condition and may be harmful to the child.

ROLE OF METAMUCIL® IN ESTABLISHING PROPER BOWEL HABITS IN CHILDREN

Metamucil's bland, demulcent bulk is a physiologic way to manage bowel dysfunction in youngsters.

Metamucil does more than merely clear the constipated bowel. When taken with adequate amounts of water, Metamucil's hydrophilic colloid has a proved corrective effect on the child's misfunctioning intestines. Use of Metamucil early in life assures a natural method of elimination and helps guard against formation of the "laxative habit" in later years.

Mixed with fruit juice, milk or the child's favorite beverage, Metamucil provides a gentle, corrective stimulation to peristalsis. There is never a "rush"—never a weakening diarrhea with Metamucil.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE Research in the Service of Medicine

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

GAMMA GLOBULIN ALLOCATED FOR MEASLES

The Office of Defense Mobilization has announced that the basic allocation of gamma globulin to Michigan for the prevention of hepatitis and the prevention and modification of measles for 1953 will be 60,900 cc., or 30,450 2 cc. vials. This figure was arrived at by arbitrarily choosing the median year during 1947 through 1951 and multiplying this figure by 3 cc. The median year for Michigan during this period happened to be 1949 when 20,279 cases of measles were reported. The 60,900 represents this figure multiplied by three after rounding off the 279 to 300.

Since Michigan's basic allocation was based on cases of measles reported by the various health jurisdictions in 1949, it would appear equitable that the supply of gamma globulin be reallocated back to the health jurisdictions in proportion to the number of reported cases for 1949.

In those health jurisdictions having full-time health departments, the health department will serve as the distribution station. Physicians may obtain gamma globulin within the limits of the available supply upon reporting the name and address of a case and the ages and approximate weights of the contacts who are to receive the gamma globulin. Arrangements are being worked out for some other distribution plan for the thirteen counties without full-time health service.

Since the supply of gamma globulin is so limited, it is essential that it be conserved in every way possible. Certainly, its use should be restricted to children five years of age and under, and rarely for an older child if a concurrent illness makes it imperative. Because of the short supply it may be necessary to limit its use to contacts age three years and under. Also the dose administered to any child should be based on the actual weight of the child according to the dosage schedule accompanying the product. The tendency has been to give each contact one 2 cc. vial irrespective of weight. This obviously would result in the passive prevention of measles in a large number of smaller children with the result that later on in the measles season, they would be reinfected when their passive immunity wore out.

This is a preliminary proposal and subject to modification if more gamma globulin becomes available. There is no guarantee that the amount will be increased nor do we have any exact knowledge as to when Michigan's total allotment will be received by the Department.

SUMMER TRAINING FOR VISION AND HEARING TECHNICIANS

Summer short courses are being planned to train locally employed persons to do vision and hearing screening as a part of community programs sponsored by local health departments, physicians and school authorities. An attempt will be made to offer the training sessions in teachers' colleges in several parts of the state, depending upon requests which indicate interest in planning for vision and hearing programs next year. Stipends will be available for room and board for persons who are recommended by local health departments.

HOUGHTON LABORATORIES HAVE NEW DIRECTOR

Alden Scott became director of the Houghton laboratories of the department on April 1, succeeding Ora M. Mills who retired after 33 years of service in that capacity. Mr. Scott has been in the Grand Rapids laboratories since 1945.

MANISTEE-MASON COUNTY HEALTH DEPARTMENT FORMED

Manistee and Mason counties have joined to form a district health department effective April 1. The main office will be located in Manistee. Until a full-time director is appointed, an acting director will serve in each county.

FOR VISUALLY HANDICAPPED PRESCHOOL CHILDREN

Of interest to parents of visually handicapped preschool children is announcement of the Annual Parent Institute and Play School for parents and their visually handicapped preschool children to be held at the Michigan School for the Blind in Lansing on September 2 to 5. The Department is again co-operating with the School in promoting attendance at the Institute. Inquiries should be addressed to Wallace J. Finch, Superintendent of the Michigan School for the Blind.

NEW LOCAL HEALTH DIRECTOR

Paul J. Christenson, M.D., became director of the Isabella-Mecosta-Osceola Health Department on March 18, coming to Michigan from Virginia where he was director of a tri-county health department.

UNIQUE RECORD OF SERVICE

The death of the Department's oldest horse brought to light something of a record in state service. Old Frank was 20 years old and had given 400 gallons of blood to be made into antitoxin for the people of Michigan. He was on production for 11 years and had been bled 161 times for tetanus antitoxin. His death was due to natural causes, not to immunization or bleeding.

Dietary Help for your patients with these two vitamin and mineral fortified dairy foods

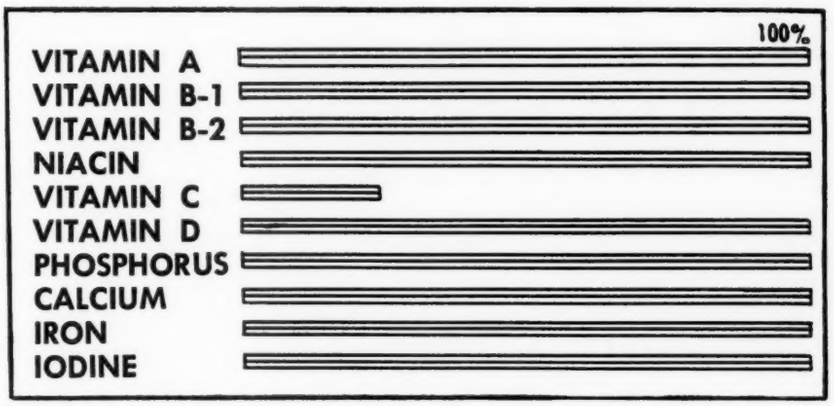
Gail Borden *Fortified* Milk

and

Gail Borden *Fortified* Skimmed Milk

This chart shows

the percent of the minimum adult daily requirements (Food & Drug Adm. Standards) supplied by one qt. of Gail Borden Milk, or one qt. of Gail Borden Skimmed Milk.



—the greatest improvement in milk since pasteurization!

Gail Borden is whole milk, fortified with additional amounts of the minerals and vitamins naturally found in milk. Gail Borden Skimed Milk is a fresh product containing not more than ½ % b.f., and fortified with the same minerals and vitamins, plus additional non-fat milk solids. Both are homogenized, and protected by the amber bottle. And both, of course, meet Borden's very strict quality standards.

Both can be of very real help in cases of protective or corrective dieting

At only one cent per quart over regular homogenized, Gail Borden Milk offers a natural, enjoyable, and economical dietary supplement; and for the low-calorie or low-fat diet, Gail Borden Skimmed Milk brings the same protection — at a still lower price. Both offer positive help in prescribing diets. And both are available at stores, or on home delivery.

The Borden Co.

Michigan Milk Division

Detroit, Michigan
Walnut 1-9000

In Memoriam

VINCENT L. BARKER, M.D., of Monroe, died February 28, at the age of fifty.

For the past twenty-one years he served the community of Monroe as a surgeon. He was graduated from the Indiana University School of Medicine in 1928 and interned at St. Luke's Hospital in Chicago. He took his residency in surgery at the Henry Ford Hospital, Detroit. Dr. Barker had been on the staff of Mercy Hospital, Monroe, since coming to the community. He was president of the Monroe County Medical Society in 1947 and was a Fellow of the American College of Surgeons.

Besides his activity in medical circles he served on the Board of Education of Monroe.

During World War II he served in the U. S. Navy for three and one-half years. His service included the building of a 500 bed hospital on Saipan. He was discharged with the rank of full commander.

Dr. Barker is survived by his wife, Martha; a son, Vincent L. Barker, Jr.; a daughter, Mrs. Robert Kallstrom; and a sister, Mrs. John Miller.

ROBERT A. BIGGS, M.D., of North Branch, died February 18, at the age of twenty-nine.

He had practiced in North Branch since 1949.

Dr. Biggs was graduated from the University of Illinois Medical School in 1947 and interned at Hurley Hospital, Flint. He served in the U. S. Navy for three years.

Dr. Biggs was on the staff of the Marlette Community Hospital and the Lapeer County Hospital. He was a member of the Lapeer County Medical Society.

He is survived by his wife, Doris; two daughters, Mary Lynne, and Shelley Ann; his mother, Mrs. Lynna Snowman, of Lapeer; and a sister, Mrs. W. E. Vivian.

GUY L. BREON, M.D., of Detroit, died February 15, at the age of sixty-eight.

Until his retirement six months ago, Dr. Breon had practiced medicine in Detroit for thirty-five years. He was a member of the staff of Harper Hospital and East Side General Hospital, Detroit. He was graduated from the University of Illinois Medical School in 1915.

Dr. Breon is survived by his wife, Agnes, and two daughters, Mrs. Clifford E. Rose and Mrs. Don E. Kelly.

GEORGE E. CLARK, M.D., of Detroit, died February 18, at the age of ninety-two.

Dr. Clark had practiced more than sixty years in Detroit. He retired two years ago from the active practice of medicine. Dr. Clark was graduated from the Detroit College of Medicine in 1888 and was a former member of the faculty. He was an Emeritus member of

(Continued on Page 548)

GEORGE E. CLARK

(Continued from Page 546)

the Michigan State Medical Society and a member of the Wayne County Medical Society.

Survivors include a nephew, Harold E. Clark, M.D., and nieces, Mrs. Wallace Mackenzie and Mrs. Frances Keller.

ROME Q. DeTOMASI, M.D., of Detroit, died February 26, at the age of sixty.

Dr. DeTomasi was graduated from Wayne University College of Medicine in 1921. He had practiced in Detroit and was on the staff of Grace Hospital.

Dr. DeTomasi is survived by his wife, Gladys; a daughter, Mrs. Stanley Loeffler; three brothers, and two grandchildren.

RUDOLPH H. LAMBERT, M.D., of Kalamazoo, died February 27, at the age of sixty-one.

Since 1930, Dr. Lambert had been medical superintendent of Fairmount Hospital in Kalamazoo. He was graduated from Wayne University College of Medicine in 1916. He interned at Providence and Herman Kiefer Hospitals, in Detroit.

During World War I, he served in the Army Medical Corps. After the war he began his specialized study of pulmonary diseases.

Before coming to Fairmount Hospital he was Assistant Medical Director at Rock Hill Sanatorium, Cincinnati, and was later Medical Director of the American Legion Hospital at Fort Custer.

Dr. Lambert was a member of the Kalamazoo Academy of Medicine, the American Trudeau Society, and the American College of Chest Physicians.

He is survived by a daughter, Mrs. Douglass F. Roy, of Richmond, Calif.; a son, John Lambert, Kalamazoo, and three grandchildren.

MARTHA L. LONGSTREET, M.D., of Saginaw, died February 26, at the age of eighty-two.

For nearly half a century she served the community of Saginaw, first as a nurse, and later as a general practitioner and pediatrician.

Dr. Longstreet received her nurses' training at Bliss Deaconess Hospital in Saginaw in 1893. She later entered the University of Illinois College of Medicine and was graduated in 1904. Dr. Longstreet came to Saginaw following her graduation and practiced as a general practitioner for ten years and as a pediatrician for thirty-five years.

Dr. Longstreet was a Life member of the Michigan State Medical Society and the Saginaw County Medical Society.

In 1938 she was designated "Michigan's Most Outstanding Woman" by the Grand Rapids Inter-Club Council of Business Women.

Dr. Longstreet was a member of the consulting staff of St. Luke's, St. Mary's, and Saginaw General Hospital.

CARL A. MITCHELL, M.D., of Benton Harbor, died March 17, at the age of seventy-three.

For almost the past half century he had served the community of Benton Harbor. Dr. Mitchell was graduated from the Bennett College of Eclectic Medicine and Surgery in 1906. Dr. Mitchell interned at the Garfield Clark Sanitarium in Chicago. He was a member of the staff of Mercy Hospital.

Dr. Mitchell was a past president of the Berrien County Medical Society and a Life member of the Michigan State Medical Society. He had also served as city health officer in Benton Harbor and was a member of the Board of Education. He was a member of the American Association of Industrial Physicians and Surgeons.

Dr. Mitchell is survived by his wife, Millie; two sons, Carl Mitchell and Robert Mitchell; and one daughter, Mrs. John D. Louth. He also leaves a sister, three brothers, and ten grandchildren.

MILES J. MURPHY, M.D., of Grand Rapids, died March 10, at the age of fifty-two.

Following his graduation from the University of Michigan Medical School in 1927, Dr. Murphy interned at St. Mary's Hospital and later opened his practice in Grand Rapids in 1929. He was chief of Staff of St. Mary's Hospital in 1951 and 1952. He was also on the courtesy staff of Blodgett and Butterworth Hospitals.

During World War II, he served in the Army Medical Corps from 1942 to 1945. Dr. Murphy was a member of the Kent County Medical Society.

Besides his wife, Catherine, he leaves three sons and two daughters. They are Miles J. Murphy, Jr., Francis Murphy, Patrick Murphy, Mary Kathleen, and Carmelita. He also leaves a brother, Dr. John D. Murphy and two sisters, Mrs. LeRoy Hewitt, and Mrs. Paul V. Gadola, of Flint.

ARTHUR L. ROBINSON, M.D., of Burr Oak, died February 17, at the age of seventy-nine.

For the past fifteen years Dr. Robinson had served the communities of Burr Oak, Bronson, Sturgis, Sherwood, and Athens. He was graduated from the Bennett College of Eclectic Medicine and Surgery in 1902. Dr. Robinson was a member of the Calhoun County Medical Society.

He is survived by his wife, Mary, and three sons. They are Fred, of Howe, Ind.; John, of Caseville, Mo., and George, of Climax.

DONALD M. SCHUITEMA, M.D., of Grand Rapids, died March 7, at the age of forty-four.

Since 1941, he has served the community of Grand Rapids as an obstetrician and gynecologist. He was graduated from Rush Medical College in 1936. Dr. Schuitema was Chief of the Obstetrics Department of Blodgett Hospital. He was also a member of the Consulting-Visiting Staff of St. Mary's and on the courtesy staff of Butterworth Hospital.

Dr. Schuitema was a member of the Kent County

Medical Society and served as a Lieutenant Colonel in the army in World War II.

He is survived by his wife, Louise; a daughter, Virginia; and a sister, Mrs. Myron Hadley of Danville, Indiana.

Communications

Dear Doctor Haughey:

I have been corresponding with Senator Ferguson for over a year now, in regard to the special issuance of a Beaumont Memorial commemorative stamp. He writes me that the prospects are good, and he has taken it up with the Postmaster General. I wish you would send him a copy of the February, 1953, JOURNAL, or send me one to send him.

Also, if more members of the Michigan medical profession would write him and encourage him, I believe it would definitely go through.

Sincerely yours,

AENEAS CONSTANTINE, M.D.

Harrisville, Michigan
February 25, 1953

* * *

Dear Editor:

We have long enjoyed your Journal, but would like to congratulate you particularly on the February, 1953 number. Beaumont has long been a favorite character, especially in Digestion Lectures, and this gives new information of value.

Yours sincerely.

W. A. FRASLEY, *The Editor*

Ontario Medical Review
Official organ, Ontario
Medical Association

* * *

Dear Doctor Haughey:

Thank you very much for the publicity given to the Association of American Physicians and Surgeons' seventh annual national Essay Contest for high school students, published in the February, 1953, JOURNAL of the Michigan State Medical Society.

Based upon the number of free packaged libraries which AAPS furnishes to participating county and state medical societies, the Essay Contest has grown to eighteen times the size of the first Contest sponsored seven years ago.

Co-operation such as yours has contributed largely to the steadily increasing acceptance of the Contest and to its unusual success.

With very best wishes to you and your Michigan colleagues, I am

Sincerely,

CHARLES L. FARRELL, M.D.
President, AAPS

February 26, 1953

. . . . . NEWS MEDICAL

HELP MAKE A 3,000 ATTENDANCE RECORD IN GRAND RAPIDS
MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

MICHIGAN AUTHORS

Plinn F. Morse, M.D., of Detroit, is the author of an article, "Remarks on Pathology and Its Role in the Practice of Ophthalmology and Otolaryngology," published in *Transactions American Academy of Ophthalmology and Otolaryngology,* January-February, 1953.

Osborne A. Brines, M.D., of Detroit, is the author of an article, "Cor Pulmonale," published in *Arizona Medicine,* March, 1953.

Edward P. Cawley, M.D., University of Virginia Medical School, Charlottesville, Virginia, formerly Assistant Professor of Dermatology, University of Michigan, Ann Arbor, is the author of an article, "Common Diseases of the Scalp," published in *The American Academy of General Practice,* March, 1953.

Carey P. McCord, M.D., of Ann Arbor, is the author of an article, "Science Miniature-Dancing Feet," published in *Industrial Medicine and Surgery,* March, 1953.

A. C. Furstenberg, M.D., of Ann Arbor, is the author of an abstract, "Anatomic Considerations of Ménière's Disease," published in *American Practitioner Digest of Treatment,* March, 1953.

Stefan S. Fajans, Department of Internal Medicine, is the author of an abstract, "Recent Advances in the Management of Diabetic Coma," published in the *University of Michigan Medical Bulletin,* February, 1953.

H. M. Pollard, M.D., and **R. J. Bolt, M.D.,** Department of Internal Medicine, are the authors of an abstract, "Potassium Balance in Ulcerative Colitis," published in the *University of Michigan Medical Bulletin,* February, 1953.

Alexander Blain, III, M.D., of Detroit, is the author of an article, "Scalenus Anticus Syndrome Precipitated by an Attack of Pleurisy," published in *Surgery,* December, 1952.

James Clark Maloney, M.D., of Birmingham, has sent us a copy of the February, 1953 issue of the *Tokyo Journal of Psychoanalysis,* at the request of Kenji Ohtsuki, Editor of the Journal. With the exception of two pages this journal is printed in Japanese. The February issue, contains a translation of an article by Dr. Maloney which was first published in THE JOURNAL of the Michigan State Medical Society, August, 1947.

* * *

The Mount Carmel Mercy Hospital annual clinic day, January 28, was very successful, with over 550 in attendance, some coming from the Upper Peninsula.

Nearly a full page of the March 30 issue of *Newsweek* magazine is devoted to an enthusiastic report of how the AMA and state and county medical societies have helped to eliminate the causes of complaints voiced by patients that doctors keep people waiting in their offices too long; that they are cold and impersonal, and that they are inept at handling medical fees.

The *Newsweek* story grew out of a seminar on the subject, "Patients Are People," which the Medical Society of the District of Columbia held recently for physicians' office aides. Interest in the meeting was so high that more than 500 persons jammed the society's auditorium and many had to be turned away.

A *Newsweek* Washington correspondent gathered much of his story material from the discussion itself and later interviewed Carol Towner, of the AMA Public Relations Department, who attended the session. She authored the popular pamphlet, "Winning Ways With Patients," which was distributed to all physicians by the AMA a few months ago. The pamphlet pin-points how best to solve problems that would improve doctor-patient relationships.

* * *

The Sixth Annual Clinic Day of the Bon Secours Hospital will be held June 9, 1953.

* * *

A scientific editorial in *The Journal of American Medical Association* March 28, 1953, refers to a paper by Drs. E. C. Texter and D. H. Kaump which appeared in THE JOURNAL of the Michigan State Medical Society, September, 1948.

* * *

1st Lt. Fae M. Adams, MC, of San Jose, California, was sworn in March 11, 1953 as the first woman physician to be commissioned in the U.S. Regular Army at ceremonies attended by Maj. Gen. George E. Armstrong, Army Surgeon General and representatives of the Army's women service groups.

* * *

The Army Medical Service has broadened its tests of dextran, a plasma substitute derived from sugar, to include all medical units in this country and oversea theaters, Major General George E. Armstrong, MC, the Surgeon General, announced. Army physicians have been authorized to requisition and use dextran wherever

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they believe it may be suitably employed in place of plasma.

Extensive trials of dextran in military and civilian hospitals in the United States and on combat casualties in Korea have shown that the polysaccharide plasma expander possesses many of the qualities of blood plasma and may eventually supplant plasma if present findings are confirmed.

* * *

The Louisiana State Medical Society, in conformity with the action and direction of the House of Delegates, effective January 1, 1953 changed the name of its journal from *The New Orleans Medical and Surgical Journal* to *The Journal of the Louisiana State Medical Society.*

* * *

Physical Medicine and Rehabilitation.—The American Congress of Physical Medicine and Rehabilitation will hold its thirty-first Annual Scientific and Clinical Session at the Palmer House, Chicago, August 31, through September 4, 1953. For further information write Walter J. Zeiter, M.D., Executive Director, American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Avenue, Chicago 2, Illinois.

* * *

Meeting of X-Ray Technicians.—The first international convention of x-ray technicians is scheduled June 28, through July 2, 1953, at the Royal York Hotel, Toronto, Canada. The meeting is sponsored jointly by the Canadian Society of Radiological Technicians and the American Society of X-Ray Technicians. Additional information may be obtained by contacting Robert J. Vennie, R.T., 426 Oneida Street, Portage, Wisconsin.

* * *

Tuberculosis Symposium.—The Second Annual Tuberculosis Symposium for General Practitioners will be held July 13-17, at Saranac Lake, New York. The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The meeting is approved by the American Academy of General Practice for twenty-six hours of formal credit for its members. Complete information concerning the program can be obtained by writing Richard P. Bellaire, M.D., Tuberculosis Symposium for General Practitioners, P.O. Box 707, Saranac Lake, New York.

* * *

Summer Camp for Diabetic Children.—For the fifth season, the Chicago Diabetes Association, Inc., will conduct a summer camp for diabetic children from July 21, 1953, to August 10, 1953, at Holiday Home, Lake Geneva, Wisconsin. Boys and girls between the ages of eight and fourteen years, inclusive, will be accepted for the three-week camping period. The fee is $150 and covers the three-weeks outing and transportation from Chicago. (Fee reductions may be arranged when considered necessary.) Besides the regular camp personnel,

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there will be a staff of dietitians and resident physicians trained in the care of diabetic children. Doctors of medicine are requested to notify parents of diabetic children and to supply the names of the children who would like to attend the camp. Inquiries and applications should be addressed to Service Unit, Chicago Diabetes Association, 110 S. Dearborn Street, Chicago 3, Illinois.

* * *

Genesee Cancer Day.—More than 200 doctors of medicine from Michigan and nearby areas attended the Eighth Annual Cancer Day program of the Genesee County Medical Society on April 8. L. W. Hull, M.D., Detroit, President-Elect of MSMS, presided at the morning session and Clifford H. Keene, M.D., Ann Arbor, Chairman of the MSMS Cancer Control Committee, presided in the afternoon. Six nationally known authorities on cancer detection, treatment and research, spoke at the meeting which was held in Hurley Hospital, Flint.

* * *

V. A. Hospital Manager Appointed.—Morley B. Beckett has been appointed manager of the new 496-bed Veterans Administration Hospital at Ann Arbor, Michigan. The Ann Arbor Hospital is scheduled to be opened this summer. Dr. Beckett has been manager of the Veterans Administration Hospital at Saginaw since 1950.

* * *

Leo H. Bartemeier, M.D., Detroit, was appointed to the National Manpower Council by Dr. Grayson Kirk, President of Columbia University, New York City. The Council was established by President Eisenhower at Columbia in 1951, to provide a continuing appraisal of America's manpower resources. The Council operates under a Ford Foundation Grant and its activities are centered at the Columbia University Graduate School of Business.

* * *

The Michigan State Board of Registration in Medicine announces that licensure examinations will be held concurrently in Ann Arbor and Detroit on June 10, 11, and 12, beginning promptly at 8:30 A.M.

Tentative arrangements have been made to use the Waterman Gymnasium for the examination at the University of Michigan and the Auditorium of the College of Medicine at Wayne University.

* * *

The inauguration of Dr. Edward J. McCormick of Toledo, Ohio, as President of the American Medical Association will be carried by the American Broadcasting Company radio network on Wednesday night, June 3, it has been announced by AMA headquarters in Chicago.

The inaugural ceremony at the 102nd Annual Session of the AMA in New York City will be heard over more than 300 ABC stations in this country, Alaska and Hawaii. Except for some local variations because of station program schedules, the inauguration will be car-

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ried at 10 to 10:30 P.M. in the Eastern Time Zone and 9 to 9:30 P.M. in all other time zones.

The actual inaugural ceremony will take place Tuesday night, June 2, in the Hotel Commodore, but it is expected that practically all radio and television time that night will be disrupted by special news and film programs on the coronation of Queen Elizabeth. It therefore will be necessary to transcribe the program for a delayed broadcast on Wednesday night.

Also originating from the AMA New York meeting this year will be the popular "Dr. Christian" radio program, featuring the well-known actor, Jean Hersholt. This program, which will be staged and transcribed Tuesday night one hour prior to the inaugural ceremony in the Grand Ballroom of the Hotel Commodore, also will be re-broadcast on Wednesday night. It will be carried by the Columbia Broadcasting System.

All physicians who will not be in New York for the AMA meeting are urged to watch the radio listings in their newspapers for the local broadcasting times of the ABC inaugural program and the CBS "Dr. Christian" show, both on Wednesday night, June 3.

AMERICAN THERAPEUTIC SOCIETY

The annual meeting of the American Therapeutic Society will be neld in the Hotel Biltmore in New York City on May 28-31, 1953.

Outstanding in the program is a Symposium on Tobacco, which includes the following:

Moderator—ARTHUR C. DEGRAFF, M.D., New York

"The Allergic Response to Tobacco"—W. C. SPAIN, M.D., New York

"The Influence of Smoking upon the Gastro-Intestinal Tract."—ROBERT C. BATTERMAN, M.D., New York

"Evaluation of the Effects of Tobacco Smoking in Relation to the Central Nervous System, Organic or Psychiatrically"—H. RANDOLPH UNSWORTH, M.D., New Orleans

"Vascular Responses to Tobacco"—A. WILBUR DURYEE, M.D., New York

"The Effects of Smoking of Nicotine on the Cardiovascular System of Normal Persons and Patients with Hypertension"—GRACE ROTH, M.D., Mayo Clinic

"The Pharmacology of Tobacco"—HARVEY B. HAAG, M.D., Richmond

"Role of Tobacco in Pulmonary Cancer"—ERNEST L. WYNDER, M.D., Memorial Hospital, New York

Round-Table Discussion

In addition are two symposiums:

"Recent Advances in Medicine"—O. P. J. FALK, M.D., St. Louis.

"Recent Advances in Surgery"—W. WAYNE BABCOCK, M.D., Philadelphia.

One entire day will be devoted to new items in the therapeutic armamentarium.

Guests are welcome to attend these scientific sessions.

University of Michigan Medical School students were guests at the Parke, Davis & Company Laboratories in Detroit on February 18-19, 1953.

L. Fernald Foster, M.D., Bay City, MSMS Secretary, was guest speaker at a joint meeting of the Bay County (Florida) Medical Society and its Woman's Auxiliary which was held in Panama City, Florida, on March 30. Dr. Foster's topic was "The Battle of the Ballot for Bay City General Hospital." More than 100 doctors of medicine and their wives and guests were present.

* * *

Legal Institute.—The Michigan Hospital Association in co-operation with Michigan State College is conducting an Institute on "Legal Aspects on Hospital Operation and Management." The Institute will be held Wednesday, Thursday, and Friday, May 27-28-29, at the Kellogg Center in East Lansing. J. Joseph Herbert, L.L.B., Manistique, Legal Counsel of MSMS, has been invited to discuss the topic "Legal Responsibility of the Hospital for the Care and Treatment of Patients."

* * *

Hill-Burton Hospital Construction in Michigan.—As of March 1, 1953, Hill-Burton Hospital Construction in Michigan included twenty-six projects completed and in operation at a total cost of $21,636,341, including a federal contribution of $8,123,893 and supplying 1,466 additional beds. According to the report, there were fourteen projects under construction at a total cost of $15,487,208 with a federal contribution of $5,815,527 and designated to supply 769 additional beds. There are eight projects that have been approved but are not as yet under construction. These projects will cost $6,729,700 and supply 442 additional beds.

* * *

Wilfrid Haughey, M.D., Battle Creek, presided at a Conference of the American Association of University Women, February 21. Dr. Haughey introduced the speakers who included his son-in-law, Don Dolan, and Robert Koopman of the Department of Education. The topic under discussion at the meeting was "Our Foreign Relations with Special Interests in Europe." Dr. Haughey spoke on March 2, before the Battle Creek Business and Professional Women's Association and discussed the topic "Medical Economics." He also spoke at the Soroptomist Club of Battle Creek, March 26, the topic, "Health and Medical Relations."

* * *

E. W. Schnoor, M.D., Grand Rapids, was named President-Elect of the Federation of State Medical Licensing Boards of the United States at a meeting in

(Continued on Page 562)

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Chicago in February. Dr. Schnoor takes office as President of the organization in February, 1954.

* * *

Tuberculosis Cases.—In 1951 among new cases classed as active pulmonary tuberculosis, three of every four (2,437 of 3,287) were in advanced stages. It is probable that all of them had already spread infection before they could be brought under isolation and treatment.

Among new cases classed as inactive and arrested pulmonary tuberculosis, one of every four (468 of 1,671) were further classed as moderately or far advanced. These, too, had been potential sources of infection for unknown periods of time.

Here are nearly 3,000 reasons for Michigan's continuing high tuberculosis case load.

UPPER PENINSULA MEDICAL SOCIETY
58th Anniversary Meeting
June 19-20, 1953
Ludington Hotel, Escanaba, Michigan

Speakers:

Moses Cooperstock, M.D.,, Marquette
Pediatrics
Lowell D. Snorf, M.D., Northwestern University
Internal Medicine
Francis Senear, M.D., Chicago, Illinois
Dermatology
L. W. Freeman, M.D., University of Indiana
Neuro-Surgery
Carl Davis, Jr., M.D., Chicago, Illinois
Cardiac Surgery
Jack A. Klieger, M.D., Milwaukee, Wisconsin
Obstetrics
Robert Baldwin, M.D., Marshfield, Wisconsin
Internal Medicine
Bruce Fralick, M.D., University of Michigan
Ophthalmology
John L. Emmet, M.D., Mayo Clinic, Rochester, Minn.
Urology
Dean Mehas, M.D., Pontiac, Michigan
General Practice
John Steele, M.D., Milwaukee, Wisconsin
Chest Surgery

Saturday, June 20
(Afternoon) Recreation period
(Evening) Banquet, with ladies invited.

BON SECOURS HOSPITAL
Sixth Annual Clinic Day Program
Tuesday, June 9, 1953

Morning Session—9:45 A.M.
General Chairman for Program
E. Gordon Aldrich, M.D.

Moderator—Donald N. Sweeny, Jr., M.D.

9:45 Modern Concepts of Arteriosclerosis.....
Hugh Stalker, M.D.
10:00 Recent Advances in the Understanding and Treatment of Shock.....C. J. France, M.D.
10:15 Gamma Globulin—Its Uses Today.....
I. F. Burton, M.D.
10:30 The Physician, Himself, As a Therapeutic Agent.....H. H. Sadler, M.D.
10:45 Glaucoma in General Practice..A. D. Beam, M.D.

Moderator—Lyle E. Heavner, M.D.

11:00 Congenital Urologic Lesions in Children.....
G. W. Sewall, M.D.
11:15 Solitary Cyst of the Kidney.....
Watson Beach, M.D.
11:30 Gangrene of the Testicle.....I. G. Downer, M.D.
11:45 Esophageal Hiatus Hernia..J. B. Hartzell, M.D.
12:00 Osseous Defects—Lumbo-Sacral Joint.....
F. J. Kelley, M.D.
12:15 Plastic Surgery in Carcinoma of Head and Neck.....E. J. Hill, M.D.

Luncheon—12:30 P.M.

Luncheon will be served by courtesy of the Sisters of Bon Secours Hospital. The meeting will be adjourned until the evening session.

Evening Session—8:00 P.M.

Moderator—Nelson M. Taylor, M.D.

8:00 One Thousand Appendicectomies, a Clinico-pathologic Correlation.....J. A. Kasper, M.D.
8:15 Irradiation and Surgical Treatment of Deafness.....J. E. Coyle, M.D.
8:30 Tetanus—An Unusual Case.....
D. N. Sweeney, Jr., M.D.
8:45 Abnormalities of the Placenta.....
R. G. Swanson, M.D.
9:00 The Surgical Management of Lesions of the Liver and Bile Ducts in Infants and Children.....Clifford Benson, M.D.
9:15 Roentgen Study of the Acute Abdomen.....
E. F. Lang, M.D.
9:30 Diagnostic Cerebral Arteriography.....
G. R. Granger, M.D.
9:45 Some Psychosomatic Aspects of Convulsive Disorders.....H. W. Bird, M.D.

A buffet supper will be served by courtesy of the Medical Staff of Bon Secours Hospital. All members of the Medical Profession are cordially invited.

All papers will begin and end on time. There will be some opportunity for a short discussion at the conclusion of each paper.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE ANATOMY OF THE NERVOUS SYSTEM. Its Development and Function. By Stephen Walter Ranson, M.D., Ph.D., Late Professor of Neurology and Director of Neurological Institute, Northwestern University Medical School, Chicago. Revised by Sam Lillard Clark, M.D., Ph.D. Professor of Anatomy, The Vanderbilt University School of Medicine, Nashville. Ninth Edition. 434 illustrations, 18 in color. Philadelphia: W. B. Saunders Co., 1953. Price $8.50.

The reviewer has been acquainted with this textbook for the past fifteen years. During that time there have been changes but only relative to the inclusion of new information. The format has remained unchanged. The revision by its present author follows the style of the previous editions. New information is now presented in those fields which in the past reported a dearth of knowledge. There is reference especially to the olivary bodies, the formatio reticularis and sensory representation in the cerebellum. There is a much more complete presentation of the functioning of the cerebellum and the symptoms that result from damage to that organ.

As with previous editions, this is principally a class room textbook. The illustrations in the gross anatomy section have not been made more voluminous nor clear. A change in that section would seem to enhance the value of the book. There is a continuation in the illustrations of serial sections through the brain down to the spinal cord. These are helpful to the student in their study of the relationship of cell groups, tracts, decussations, et cetera. It appears superfluous to make comments on a work that has become standard for the past thirty-three years and now is in its ninth edition.

G.K.S.

CLINICAL OBSTETRICS. By Members of the Staff of the Pennsylvania Hospital. Edited by Clifford B. Lull, M.D., Late Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital and Robert A. Kimbrough, M.D., Director of the Division of Obstetrics and Gynecology, Pennsylvania Hospital; Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Gynecologist to the Graduate Hospital. 392 illustrations and 8 color plates. Philadelphia: J. B. Lippincott Co., 1953. Price $10.00.

This is probably one of the most comprehensive treatises on clinical obstetrics ever compiled. It certainly ranks within the first five in the field. It draws from clinical experience of twenty key members on the staff of the Pennsylvania Hospital. The subject matter embraces the anatomy, embryology and obstetrical care and the puerpural period. There is a section on the newborn and the legal aspects of obstetrical practice. The material included is colored by the experience of the authors at the Pennsylvania Hospital. We would include this as a top choice in the obstetrical library.

R.J.C.

PHEOCHROMOCYTOMA AND THE GENERAL PRACTITIONER. By Joseph L. DeCourcy, M.D., and Cornelius B. DeCourcy, M.D., authors of Pathology and Surgery of the Thyroid. Cincinnati: DeCourcy Clinic, 1952.

This review is a well-presented consideration of the history, diagnosis and treatment of pheochromocytoma, with especial consideration of a case report published in THE JOURNAL of the Michigan State Medical Society, December, 1951, by Drs. Lloyd T. Iseri, Douglas Chandler, Gordon B. Myers and Albert J. Boyle. There have been additions, and other material used, but a goodly section of the book is based on that article. This condition of extreme hypertension and its relief through surgery, if caused by the peculiar tumor of the adrenal gland, is intriguing. We shall soon have another paper on a similar topic.

W.H.

SYNOPSIS OF OBSTETRICS. By Jennings C. Litzenberg, B.Sc., M.D., F.A.C.S., Late Professor Emeritus of Obstetrics and Gynecology, University of Minnesota Medical School, Minneapolis. Fourth edition, revised by Charles E. McLennan, M.D., Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco. 157 illustrations, including 5 in color. St. Louis: The C. V. Mosby Co., 1952. Price $3.50.

This is a coatpocket, very comprehensive edition which covers every phase of obstetrical practice. The subject matter is well organized and is arranged in one-two-three order without historical background or explanatory references. This is an excellent book for either the student or general practitioner. It will serve as a ready reference book.

R.J.C.

RECEIVED FOR REVIEW

Magazines and Pamphlets

The Scandinavian Journal of Clinical and Laboratory Investigation Supplementum 4 (Vol. 4). The Pulmonary Circulation at Rest and on Effort in Mitral Stenosis by Harald Eliasch. Printed by Ivar Haeggstroms Boktryckeri, A.B., Stockholm, 1952.

The Scandinavian Journal of Clinical and Laboratory Investigation. Edited for The Scandinavian Society for Clinical Chemistry and Clinical Physiology (Vol. 4), 1952, No. 3. Published by Medisinsk Fysiologisk Forenings Forlag, Oslo.

ACTA Psychiatrica et Neurologica Scandinavica. Supplementum 79. A Study in Manic-Depressive Psychosis Clinical, Social and Genetic Investigations by Ake Stenstedt. Norregade 6, Copenhagen: Ejnar Munksgaard, 1952.

ACTA Psychiatrica et Neurologica Supplementum 56. Microphthalmos and Anophthalmos With or Without Coincident Oligophrenia; a Clinical and Genetic-Statistical Study by Torsten Sjogren and Tage Larson. Norregade 6, Copenhagen: Ejnar Munksgaard, 1949.

ACTA Psychiatrica et Neurologica Scandinavica Supplementum 82. Morbus Alzheimer and Morbus Pick. A

Genetic, Clinical and Patho-Anatomical Study by Torsten Sjogren, Hakon Sjogren and Ake G. H. Lindgren. Norregade 6, Copenhagen: Ejnar Munksgaard, 1952.

The Harvard School of Public Health Annual Report, 1950-51. Cambridge: Harvard University, 1952.

Books Received

CHLOROPHYLL IN MEDICINE. Scientific Background. Clinical Experience in Topical Therapy. Mount Vernon, N. Y.: The Rystan Company. Free.

BUILDING AMERICA'S HEALTH. The Report of the President's Commission on the Health Needs of the Nation. 272 pages. Washington: Government Printing Office, $1.50.

A FRIEND IN CONGRESS

(Continued from Page 540)

byists. It publishes three newsletters, a bulletin, *Capitol Clinics,* and special bulletins.

The total expense of this operation, including all the salaries, is $200,000 a year. This sum has received the very special New Deal treatment of having a couple of ciphers added. This information was elicited by Congressman Hoffman, and placed on file to forever squelch the Truman and Ewing charge of a tremendous lobby. Our thanks and appreciation are due Mr. Hoffman.

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LOCUM TENENS—General practice in Detroit area from July 1, 1953, to January 1, 1954, by University of Michigan Medical School graduate, with rotating internship Philadelphia General Hospital. Michigan license. Mayo Foundation fellowship beginning January 1, 1954, Robert Caplinger, M.D., c/o Philadelphia General Hospital, Philadelphia, Pennsylvania.

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THE JOURNAL
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VOLUME 52 JUNE, 1953 NUMBER 6

Contributors to This Issue

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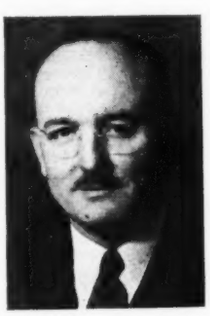
P. C. Kronfeld, M.D.



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J. G. Molner, M.D.

L. A. Schwartz, M.D.

Philip Thorek, M.D.

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of the Michigan State Medical Society

VOLUME 52 JUNE, 1953 NUMBER 6

Office of Publication
2642 University Avenue
Saint Paul 14, Minnesota

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All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone 57125.

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 14, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

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You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Pantlind Hotel-Civic Auditorium, Grand Rapids
Wednesday-Thursday-Friday, September 23-24-25, 1953
YOU ARE URGED TO ATTEND!

CHANGES IN ARMY MEDICAL INTERN PROGRAM

The length of time that Army interns will spend in the different hospital sections or services will be changed beginning July 1, the Education and Training Division, Office of the Army Surgeon General, has announced. The Division explained that the changes are in accordance with the requirements of the Council on Medical Education and Hospitals of the American Medical Association.

Under the new plan, medical interns in Army hospitals will spend three months in Internal Medicine, three months in Surgery, two months in Obstetrics and Gynecology, two months in Pediatrics and two months in a service that they select on the basis of personal preference. Electives open to the interns are Laboratory Service, Ophthalmology Section, Otolaryngology Section, and the Physical Medicine, Psychiatry and Neurology, and Radiology Services.

The program currently in effect allows the intern four months in Surgery, including Urology and Orthopedics, four months in Medical Service, including Pediatrics and Contagious Diseases, two months in Obstetrics and Gynecology, one month in Psychiatry and Neurology and one month for an elective chosen from among the following: Laboratory Service, Ophthalmology Section, Otolaryngology Section and Physical Medicine.

A total of 150 medical school graduates will intern in Army hospitals during the year 1953-54. Hospitals participating in the intern program are Army and Navy Hospital, Hot Springs, Ark.; Brooke Army Hospital, Fort Sam Houston, Tex.; Fitzsimons Army Hospital, Denver, Colo.; Letterman Army Hospital, San Francisco, Calif.; Madigan Army Hospital, Tacoma, Wash.; Murphy Army Hospital, Waltham, Mass.; Percy Jones Army Hospital, Battle Creek, Mich.; Tripler Army Hospital, Moanalua, Oahu, Hawaii; Valley Forge Army Hospital, Phoenixville, Pa.; Walter Reed Army Hospital, Washington, D. C.; and William Beaumont Army Hospital, Fort Bliss, Tex.

OSLER HELPS BEAUMONT MEMORIAL

A contribution to the Beaumont Memorial, now being erected on Mackinac Island by members of the Michigan State Medical Society, has been made by the celebrated Sir William Osler, M.D., through W. W. Francis, M.D., Librarian at McGill University, Montreal.

The late Doctor Osler, noted English physician of Canadian birth, has been dead for thirty-three years, but the contribution was made possible through his scientific achievements while he lived.

The contribution was sent to A. H. Whittaker, M.D., Detroit, by Dr. Francis of McGill, where Osler has a library of 7,500 titles. The money came from the royalty account of the Osler Library. For years, Osler's "Principles and Practice of Medicine" has been a standard textbook.

Thus one great physician has contributed to the shrine of another.

Work on the Michigan shrine to Beaumont began on March 26, 1953. The cornerstone will be laid on Friday, July 17, 1953, with appropriate ceremonies. The actual dedication of the completed Memorial will be held one year later—on Saturday, July 17, 1954, at Mackinac Island.

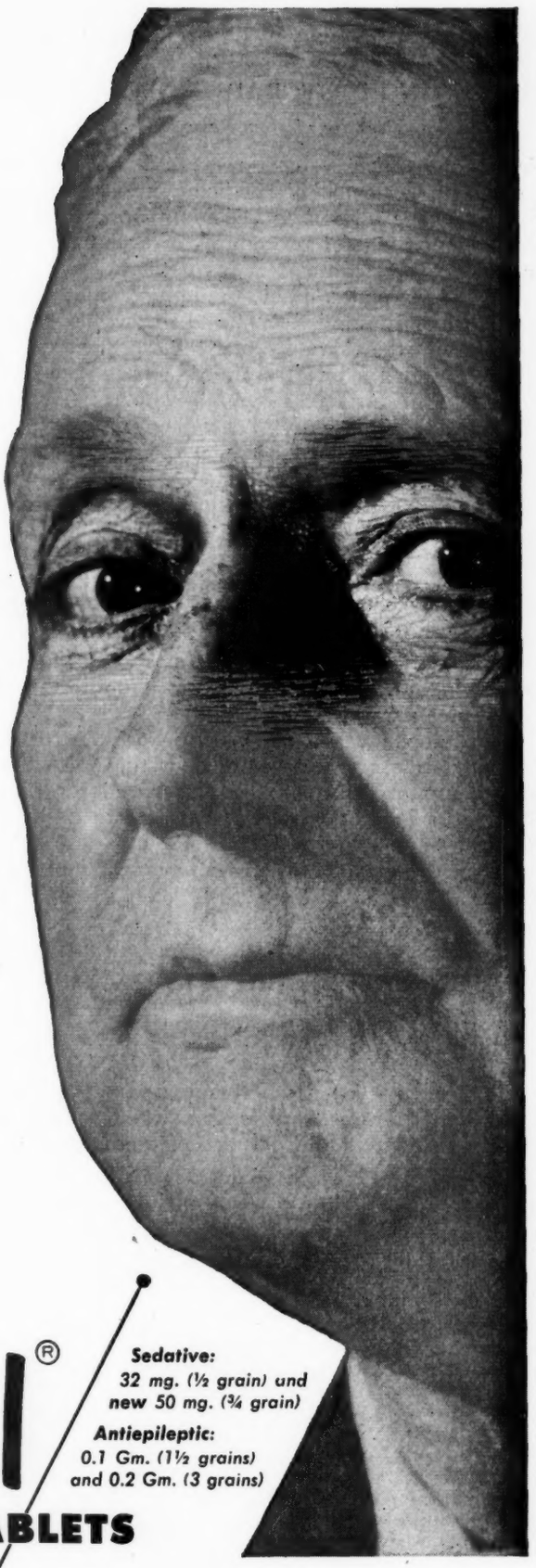
DEDUCTING POSTGRADUATE COSTS IN INCOME TAX REPORT

The U.S. Circuit Court of Appeals, Second Circuit, New York, recently decided a federal income tax case of considerable importance to the doctor of medicine.

For years, the Commissioner of Internal Revenue has ruled that expenses incurred by a physician in pursuing postgraduate medical education were personal in nature and not deductible for income tax purposes, in spite of the fact that the Internal Revenue Department permitted physicians to deduct, for income tax purposes, the costs of attending medical meetings (and also subscriptions to scientific publications and dues paid to medical organizations). It was difficult for the medical profession to appreciate what distinction could logically and legally be made between these

(Continued on Page 576)

Relaxed but awake



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DEDUCTING POSTGRADUATE COSTS

(Continued from Page 574)

deductions which were allowed and the costs incurred by a doctor of medicine in attending a formal course offered to keep him up to date in the advancement of procedures of essential value to him in the treatment of his patients.

The AMA attempted to induce the Commissioner of Internal Revenue to review his earlier decision but the Commissioner refused. Therefore, the AMA filed a brief as amicus curiae in a case before the U.S. Tax Court in which a lawyer, named Coughlin, had been denied the right to deduct expenses incurred by him in attending postgraduate courses on taxation. The Tax Court held against Attorney Coughlin and an appeal was made to the U.S. Court of Appeals—the AMA again filing a brief.

On April 14, 1953, the U.S. Circuit Court of Appeals reversed the decision of the U.S. Tax Court, holding in effect that the lawyer could deduct for federal income tax purposes the expenses incurred by him in taking a postgraduate course dealing with taxation.

The doctor implications in the Attorney Coughlin case are being studied by the AMA and an explanatory story is being prepared for publication in *The Journal of the American Medical Association*.

Be on the lookout for this important feature in JAMA.

ATTORNEY GENERAL'S OPINION

(No. 1645)

Medicine, Practice of

The practice of psychotherapeutics constitutes the practice of medicine within the meaning of statute prohibiting the practice of medicine without a license.

J. Earl McIntyre, M.D., Secretary
State Board of Registration in Medicine
202 Hollister Building
Lansing 8, Michigan

Dear Dr. McIntyre:

By your letter of March 30, 1953, you have requested the opinion of the Attorney General on the question as to whether the practice of psychotherapy in any or all of its phases by non-medically trained people constitutes a violation of Act No. 237, Public Acts of 1899, as amended, 14.539, Mich. Stat. Ann.

The foregoing section defines the practice of medicine as "the actual diagnosing, curing or relieving in any degree, or professing or attempting to diagnose, treat, cure or relieve any human disease, ailment, defect, or complaint, whether of physical or mental origin, by attendance or by advice, or by prescribing or furnishing any drug, medicine, appliance, manipulation or method, or by any therapeutic agent whatsoever."

We are advised that psychotherapeutics, psychotherapy, constitutes (1) psychiatry; (2) mental therapeutics, mind-cure, or cure by making mental impressions or suggestions.

Section 14.537, Mich. Stat. Ann., prohibits the practice of medicine or surgery in this state without a license, and the Attorney General is of the opinion that the practice of psychotherapy comes within the definition of the practice of medicine found in the statute. In the case of *People v. Mulford,* 125 N.Y.S. 760, the treatment of ailments by suggestive therapeutics was held to be the practice of medicine.

Yours very truly,
FRANK G. MILLARD
Attorney General of Michigan

April 22, 1953.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

April 23, 1953

Fifty-seven items were presented to the Executive Committee of The Council at its April meeting. Chief in importance were:

- Monthly financial reports were presented, studied and approved. Bills payable were presented and payment was authorized. The quarterly financial report of the Cancer Control Committee, to March 31, was presented and approved.
- *MSMS Representatives.*—C. J. Stringer, M.D., Lansing, was appointed as MSMS representative to attend meetings covering Study of Nursing Needs in Michigan. G. E. Anthony, M.D., Flint, chairman of the MSMS Child Welfare Committee, was appointed as MSMS representative to attend the Michigan Welfare League Conference of April 18. Moses Cooperstock, M.D., Marquette, was selected as MSMS representative to attend the fourth conference on Physicians and Schools, Highland Park, Illinois, September 30.
- R. A. Johnson, M.D., Detroit, was appointed as a member of the Rural Medical Service Committee. Edward F. Kickham, M.D., Saginaw was appointed a member of the Emergency Medical Service Committee.
- *Committee Reports:* The following were given consideration: (a) Medical Advisory Committee to Michigan Hospital Service, meeting of March 19: a breakfast to be held in Grand Rapids on Thursday morning, September 24, during the MSMS Annual Session, to acquaint the MSMS membership with the work of this committee, was authorized; (b) Study Committee on Basic Science Act, meeting of March 26; (c) Mental Hygiene Committee, meeting of April 1; (d) Legislative Committee, meeting of April 2; (e) Arbitration Committee, meeting of April 10; (f) Maternal Health Committee, meeting of April 16; (g) Beaumont Memorial Working Committee, meeting of March 18: contract between MSMS and E. J. Van Sweden, the contractor building the Beaumont Me-

(Continued on Page 578)

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 576)

morial on Mackinac Island, was reviewed; the work on the Beaumont Memorial began Wednesday, March 25, 1953. A sign describing the construction work was authorized. The cornerstone laying was scheduled for Friday, July 17, 1953, with the dedication of the completed building on July 17, 1954. Presentation by Mrs. Hugo Freund, Detroit, of a copy of one of Dr. Beaumont's original books, for housing in the Beaumont Museum, was accepted with thanks. A commemorative stamp for the Beaumont Memorial as recommended by E. E. Dufina, Postmaster on Mackinac Island, was approved—an effort to have the United States Post Office develop a Beaumont Memorial stamp, for release in July, 1954, to coincide with the dedication of the Beaumont Memorial was authorized; (h) Committee on Group Health and Accident Insurance, meeting on March 18; (i) Medical Jurisprudence Committee (a committee of the State Bar of Michigan), meetings of March 6 and of April 9: these meetings dealt mainly with provisions of the proposed medical examiner bill (S.B. 1293).

- *Remodeling front entrance of MSMS* headquarters at 606 Townsend Street, Lansing. Blueprints received from Architects Haughey & Black were presented and studied and the work was authorized.
- *The name of S. D. Steiner, M.D.,* Medical Director of Oldsmobile Division 6.M., Lansing, was submitted for the President's award to the physician making the greatest contribution to the employment welfare of the handicapped; Dr. Steiner's work is utilization of the blind in industry.
- *William Henry Gordon, M.D.,* Detroit, chairman of the MSMS Emergency Medical Service Committee, was authorized as MSMS representative to present to the American Medical Association's National Emergency Medical Service Committee the problems and suggestions his committee feels are in order regarding medical civil defense.
- *J. E. Livesay, M.D.,* Flint, was appointed as MSMS representative to work with Michigan State College on a proposed school for safe handling of x-ray equipment.
- *Tour of Sloan-Kettering Institute,* New York City, by nine Michigan M.D.'s, as guests of Mr. James Gariety of Adrian, Michigan, was reported; a vote of sincere thanks was placed on the minutes to Mr. Gariety for his interest in cancer research and control and his tangible contribution to cancer education.
- *The monthly reports* of the Council Chairman, the President, Secretary, Treasurer, Editor, Legal Counsel, Rheumatic Fever Co-ordinator, and Public Relations Counsel were presented.
- *An Institute on Medical Testimony* for doctors of medicine who do not make this work a special field of endeavor, under the sponsorship of the University of Michigan School of Public Health, is to be held in Ann Arbor in October; all MSMS members are cordially invited.
- Report was made that E. W. Schnoor, M.D., Grand Rapids, had been chosen president-elect of the National Association of Boards of Medical Examiners; congratulations were extended to Dr. Schnoor, who is president of the Michigan State Board of Registration in Medicine.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

July 30-31 Annual Coller-Penberthy Medical Surgical Conference — Traverse City

Aug. 20 Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties — Grayling

Sept. 22 Michigan Chapter, American College of Surgeons — Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION — Grand Rapids

Oct. 7 Clara Elizabeth Fund for Maternal Health and Genesee County Medical Society — Flint

Oct. 21 Michigan Cancer Conference — East Lansing

Autumn MSMS Postgraduate Extramural Courses — Statewide

1954

Mar. 10-12 MICHIGAN CLINICAL INSTITUTE — Detroit

Apr. 14 Genesee County Medical Society Ninth Annual Cancer Day — Flint

May 12 Annual Clinic Day and Alumni Reunion of the Wayne University College of Medicine, Hotel Fort Shelby — Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

ome questions about filter cigarettes hat may have occurred to you, Doctor

and their answers by the makers of Kent

Q: What materials are used in cigarette filters?

A: Until just recently, cellulose, cotton or crepe paper were the only materials used in cigarette filters.

Now, after long search and countless experiments, KENT's "Micronite"* Filter has been developed. It employs the same filtering material used in atomic energy plants to purify the air of minute radio-active particles.

Q: How effective are these cigarette filters?

A: Scientific measurements have proved that cellulose, cotton or crepe paper filters do not take out a really effective amount of nicotine and tars.

However, these same tests also have proved that KENT's exclusive Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette filter.

Q: Do physiological reactions to filter cigarettes differ?

A: The drop in skin temperature occurring at the finger tip induced by filtered cigarette smoke was measured according to well-established procedures. (a, b)

For conventional filter cigarettes, the drop was over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

Q: Does an effective cigarette filter also remove the flavor?

A: KENT's Micronite Filter . . . the first cigarette filter that really works . . . lets smokers enjoy the full pleasure of a really fine cigarette, yet gives them the greatest protection ever from tars and nicotine.

In less than a year's time, the new KENT has become so popular it outsells brands that have been on the market for years.

• • •

Today, KENTs are sold in most major U.S. cities. If your city is not yet among them, simply write to P. Lorillard Co., 119 West 40th Street, New York, N. Y., and special arrangements will be made to assure you of a regular supply.

References Cited

a. *J.A.M.A.*, Vol. 103, 1934, p. 318
b. *J.A.M.A.*, Vol. 135, 1947, p. 417

* PATENT APPLIED FOR

Heart Beats

H. L. Smith, M.D.

"It is my hope that we shall be able to continue to broaden the scope of activities of the Michigan Heart Association throughout the State during the coming year, as it is a state association and truly a child of the Michigan State Medical Society," was the keynote sounded by Henry L. Smith, M.D., of Detroit, when he assumed the office of president of the Michigan Heart Association on March 13, 1953.

"I wish to pay high tribute to Drs. Warren B. Cooksey, Paul S. Barker, Douglas Donald and F. Janney Smith who have preceded me in this office. They have done a marvelous job of building this fine organization into one of the leading voluntary health organizations in Michigan today," Dr. Smith continued. "It took much work on their part and united effort and co-operation by many other persons to attain this goal. It is my hope that during my term of office this growth and accomplishment can be continued."

Dr. Smith was elected president of the Association at its Fourth Annual Michigan Heart Day meeting which was held in Detroit in conjunction with the Michigan Clinical Institute, sponsored by the Michigan State Medical Society.

Mr. Charles E. Wilson, Secretary of Defense of the United States, was re-elected chairman of the Board of Trustees of the Association. Mr. Wilson was active in the formation of the Michigan Heart Association and has served as Board chairman since its inception.

Frank Van Schoick, M.D., Jackson, who has served actively in the Association since its organization, was chosen president-elect at the annual meeting.

Other officers elected by the Association at the March meeting were: Vice Presidents—L. Paul Ralph, M.D., Grand Rapids, Mrs. Hugh Wilson, Ann Arbor, and Carleton Dean, M.D., Lansing; Secretary—L. Fernald Foster, M.D., Bay City; Treasurer—Mr. Charles T. Fisher, Jr., Detroit.

F. Janney Smith, M.D., Detroit, the immediate past president of the Michigan Heart Association, will continue to serve on the Board of Trustees, the Executive Committee, and the Research Committee of the Association.

John G. Bielawski, M.D., Detroit, who has served as the Association's executive secretary for the past two years, was appointed to the newly created post of Medical Director of the Heart Association.

The following committee appointments were made by Henry L. Smith, M.D., following his election as president of the Michigan Heart Association:

Research Committee—Douglas Donald, M.D., Detroit, Chairman; Earle A. Irvin, M.D., Detroit; Franklin D. Johnston, M.D., Ann Arbor; E. D. Spalding, M.D., Detroit; L. Paul Ralph, M.D., Grand Rapids; James Fryfogle, M.D., Detroit; Muir Clapper, M.D., Detroit; and F. Janney Smith, M.D., Detroit.

Program Committee—Carleton Dean, M.D., Lansing, Chairman; Warren B. Cooksey, M.D., Detroit; Myer Teitelbaum, M.D., Detroit; M. S. Chambers, M.D., Flint; Robert E. Fisher, M.D., Bay City, J. K. Altland, M.D., Lansing; Ralph L. Fisher, M.D., Detroit; F. D. Dodrill, M.D., Detroit; Roy D. Tupper, M.D., Detroit; and Paul S. Barker, M.D., Ann Arbor.

Finance Committee—Mr. Frank Isbey, Detroit, Chairman; Mr. Charles T. Fisher, Jr., Detroit; and Mr. J. William Hagerty, Detroit.

Membership Committee—M. S. Chambers, M.D., Flint, Chairman; Wm. P. Chester, M.D., Detroit; Seymore K. Wilhelm, M.D., Detroit; Donald S. Smith, M.D., Pontiac; S. C. Wiersma, M.D., Muskegon; John D. Littig, M.D., Kalamazoo; and Mrs. Hugh Wilson, Ann Arbor.

Committee on Cardiovascular Clinics—Cecil Corley, M.D., Detroit, Chairman; John M. Murphy, M.D., Detroit; L. T. Colvin, M.D., Detroit.

The Michigan Heart Association is an affiliate of the American Heart Association and a member-agency of the United Health and Welfare Fund of Michigan.

I want to remind you once more that the federal government alone is still taking in taxes 52 per cent of the money we are earning for you as shareholders. I suggest the necessity for continued efforts on your part as well as ours to bring about a more reasonable tax level for enterprises like this one.—H. M. McBain, Chairman of Board, Marshall Field & Company, Annual Report.